A STUDY ON IDENTIFICATION OF SOCIO-ECONOMIC PROBLEMS, COPING PRACTICES AND POSSIBLE INTERVENTIONS FOR SENIOR CITIZENS OF ALIGARH (U.P.)

THESIS

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IN

SOCIAL WORK

BY

SHAIZY AHMED

UNDER THE SUPERVISION OF

PROF. NOOR MOHAMMAD

DEPARTMENT OF SOCIAL WORK
ALIGARH MUSLIM UNIVERSITY
ALIGARH-202 002 (INDIA)

2013

DEDICATED TO

MY LOVING PARENTS

Phones { Office : 350, 351
Res. : 401942

DEPARTMENT OF SOCIOLOGY & SOCIAL WORK
ALIGARH MUSLIM UNIVERSITY, ALIGARH-202 002

Dr. Noor Mohammad
M.A. (Eco.), M.A (Soc.), Ph.D.
Professor & Chairman

CERTIFICATE

This is to certify that Ms. SHAIZY AHMED has worked under my supervision for her Thesis entitled 'A study on identification of socio-economic problems, coping practices and possible interventions for senior citizens of Aligarh (U.P.)'. She has completed the work for the award of Ph.D degree under the provisions of academic ordinances, A.M.U., Aligarh. The work is original and suitable for the submission and award of Ph.D degree in Social Work.

Prof. Noor Mohammad
Ex-Prof. Department of
Sociology & Social Work,
A.M.U, Aligarh.

(Supervisor)

Place: Aligarh
Date: 17/04/2013

Residence : 4/1294-A, New Sir Syed Nagar, Aligarh—202 002

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Shaizy Ahmed

(Ms. Shaizy Ahmed)

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LIST OF ABBREVIATIONS

S. No	ABBREVIATION	MEANING
1.	OAPS	Old Age Pension Scheme
2.	WP	Widow Pension
3.	NPOP	National Policy for Older Persons
4.	UN	United Nations
5.	ICMR	Indian Council of Medical Research
6.	W.H.O	World Health Organization
7.	NGOs	Non Governmental Organizations
8.	B.P.	Blood Pressure
9.	QOL	Quality of Life
10.	SHGs	Self Help Groups
11.	MMU	Mobile Medicare Units
12.	PHC	Public Health Centre
13.	CD	Compact Disc
14.	PRIs	Panchayati Raj Institutions
15.	EPF	Employees Provident Fund
16.	NCOP	National Council for Older Persons
17.	NCRB	National Crime Record Bureau
18.	BPL	Below Poverty Line
19.	CPF	Contributory Provident Fund
20.	OASIS	Old Age Social and Income Security
21.	LIC	Life Insurance Corporation
22.	vs.	Versus
23.	UGC	University Grants Commission

PREFACE

Population ageing is one of the most distinctive demographic events in the world today. The Projections of United Nations Population Division showed a massive demographic shift being taking place both in the developed and developing nations. It was projected that by 2015, the developed countries alone will see the rise in the percentage of population aged sixty and above from an average of seven percent to over eleven percent. In the less developed regions, China and India alone accounts for over fifty percent of the elderly population.

Presently, the developing countries are not emphasizing much on ageing and related problems as compared to the developed world because the problem is not seen as serious as compared to the developed nations. But in years to come, it is surely going to become a serious policy challenge for all developing nations and especially to India, for having the largest share of younger generation at present. Moreover, population ageing would also accompany an increasing degree of population feminization as death rates for females tend to be significantly lower than the males.

In this regard major initiatives like World Assemblies on Ageing held at Vienna (1982) and Madrid (2002); International plan of Action on Ageing , and UN Declaration of the Year 1999 as the 'International Year of Older Persons' has all been taken to stimulate the conscience of the World towards the needs and problems of the aged. In response, the Government of India has also formulated many initiatives e.g. the formulation of National Policy of Older Persons, Provision of Old Age Pension for all States, special queues for senior citizens in hospitals and railway stations, concession in fare by Railway and other Ministries and The Maintenance and Welfare of Parents and Senior Citizens Act' 2007 respectively.

Despite all these efforts, the situation of India's elderly is still vulnerable. Vulnerability has many reasons: foremost is the involvement of handful of young scholars in qualitative research on aged; second is the involvement of limited number of NGOs in the welfare of senior citizens and finally, informal care giving is never added as a regulatory mechanism by the government in any welfare scheme or policy. Besides, the emergence of nuclear family, involvement of women in salaried jobs has

all added woes to the life of senior citizens. In a situation like this few important question emerges as; why the younger generation is incapable in fulfilling the needs of their parents and grandparents? Why they are not in a position to give love and respect to ones who served them for so long? Unfortunately, young minds are totally ignoring the elder generation and forgetting the fact that ageing is as natural as any other phase of life and one day they themselves will become old.

Hence, the present research is a minor step in the direction of locating the situation of aged in the present World. It attempts to diagnose not only the current socio-economic problems faced by the elderly; but also identify the interventions and coping practices adopted by senior citizens during the time of socio-economic and health crisis. It further attempts to identify the ways and procedures following which the senior citizens may experience successful and healthy ageing.

For this, Aligarh city of U.P. has been selected because of its manageable size, homogeneous population and researcher's familiarity with the study area. Moreover, Aligarh is an example of Modern Township with a good mix of elderly population belonging to all socio-economic stratums. Aligarh was also been chosen because of its observation of the effects of urbanization and fast changing socio-economic conditions which are responsible for bringing changes in the life styles of elderly.

The present study comprised of 500 senior citizens of age sixty and over; of which 253 were males and 247 were females. The study adopted 'Stratified Proportionate Random Sampling' technique for the selection of the respondents. In order to view the socio-economic problems of senior citizens, Interview Schedule as an instrument for data collection, was selected. Further to verify the genuineness of the findings, few Case studies were conducted.

The present work has been organized into four chapters; each dealing with an independent aspect of the research work. The First chapter gives a brief introduction of the research problem. The chapter highlighted the current scenario of population ageing in India, Asia, and across the World. It also outcasts the recent trends of population ageing in India and its corresponding states. To get a clear vision of the problem, both micro and macro perspective has been covered. The main objective of this chapter is to focus on the rationale behind the study and explain the relevance of

present work. For this, an extensive literature from various sources has been covered. The chapter deals with the various problems and perspectives of ageing. It views ageing from the side of various scholars by evaluating their theories, suppositions, beliefs and findings. In a nutshell, the chapter provides a complete understanding of the ageing phenomenon along with providing familiarity with the research problem.

The second chapter examines the various social security measures meant for the welfare of senior citizens in India. The chapter first explains the concept of social security and then highlighted the social means using which the deprivation and vulnerability of senior citizens can be removed. Hence, the chapter emphasized especially on the need and importance of social welfare programmes. It begins with the growth and development of social security measures in India and ends with the various government schemes. National Policy for Older Persons and five year plans were covered to locate the position of aged in the present context. International initiatives like Madrid plan of action and Vienna Declaration were also highlighted to understand the needs of aged at International level. Thus chapter is an attempt to determine the policy implications for elderly living in India and forecast their future needs.

The third chapter deals with the analysis and interpretation of data. The study highlighted some interesting findings: First, Senior citizens belonging to lower income group or are totally dependent considers their old age as a 'curse', whereas , those belonging to higher income group or are able to do their activities of daily living are still enjoying their old age. For them, old age is a period of freedom from responsibilities, whereas, others considered it as a period of struggle. Second; senior citizens, irrespective of their income, preferred living in their own homes rather than living in any old age home. Third, health is the most common sector which affects almost every senior citizen and hence needs special concern from policy makers and planners. Fourth, financial assets help in maintaining the quality of life of senior citizens. It changes the attitude of family members towards them. Fifth, female elderly are more vulnerable than males in terms of decision making, financial stability and social status.

The fourth chapter ends with the conclusion and suggestions. In conclusion, it was reported that senior citizens in India are having multifarious needs and requires an interdisciplinary and holistic approach. In this regard, the government should commit for having qualitative and need based research along with the provision of free services to all its senior citizens. Individual efforts of both senior citizens and younger generation should also be promoted. The senior citizens should change their mind set regarding the new values imbibed by the younger generation, focus on the limitations of old age and try to learn adjustment with new roles, whereas, the younger generation should learn the lesson of love, respect and care towards the elder generation. They should recognize their elders as heir of experience and a valuable resource rather than being a burden of responsibilities.

In a nutshell, it was concluded that joint efforts of all the stakeholders including politicians, policy makers, youth, aged and other government departments are needed in making the life of senior citizens organized. For successful research; centre for specialized training in geriatrics and gerontology, training in nursing and care giving etc. should be promoted. In addition, it could be learnt that ageing is a normal stage of life which everyone has to face. Becoming "old" is an achievement and a blessing of God rather than a curse. So everyone must think of planning his/her old age in a positive manner.

CHAPTER 1

INTRODUCTION

INTRODUCTION

The present chapter gives a brief introduction of the research problem. Population ageing is one of the most distinctive demographic events in the World today. The present chapter highlighted the current scenario of population ageing in India, Asia, and across the World. It is an attempt to outcast the recent trends of population ageing. To get a clear vision of the problem, both micro and macro perspective has been covered. Chapter's main aim is to focus on the rationale behind the study and explain the relevance of present work.

Senior citizens are generally considered as 'forgotten generation' associated with various stereotypes like that of being senile, sick, unattractive, incapable and rigid etc. The chapter therefore clarified the myths associated with ageing. This can be done in the light of scientific facts. Chapter deals with the various perspectives of ageing and evaluate various theories, suppositions and beliefs. It explains the concept of population ageing along with its indicators. It also focuses on demographic transition and tries to make an interface between population and demographic ageing. Since population ageing and individual ageing shares a 'cause-effect' relationship; the chapter therefore focuses on the concept and dimensions of individual ageing. In addition, the chapter has an extensive coverage of literature being reviewed from various secondary sources.

Hence, the present chapter not only guides the researcher about the basic concepts of ageing, but also highlights the future directions of ageing research in India. Demographic transition and population ageing are few such directions. In a nutshell, the chapter provides a complete understanding of the ageing phenomenon.

1.01: Emergence of research problem:

Population ageing, the process by which older individuals come to form a proportionately larger share of the total population, is one of the most distinctive demographic events in the World today. It is becoming one of the single most important long run fiscal challenges. The proportions of people aged sixty years and above are rising and are expected to grow further rapidly over the next fifty years.

This was like a 'demographic time bomb' or an 'age quake' which will nearly show its consequences in every nation.[1]

Ageing has become a universal phenomenon. Ageing population is not only the sole concern of developed countries, it is also becoming a critical policy issue in many of the developing world. There is no escape to ageing; however, different countries are facing or may face its impact differently based on their socio-cultural and economic characteristics. The Projections of the United Nations Population Division[2] showed a massive demographic shift being taking place in both the developed and developing countries. For instance, the population aged sixty and above in the developed countries will projected to see the percentage of the old people in their population rise from an average of seven percent to over eleven percent by the year 2015.However,in the less developed regions, China and India alone accounts for over fifty percent of the World's elderly population[3].

Presently, the developing countries are not emphasizing much on ageing and related issues as compared to the developed World. This is because the problem is not seen as serious in developing countries as compared to the developed nations. But in years to come, it will definitely throw some serious challenges to developing nations and especially to India as because of having the larger share of younger generation at present. Thus to understand the severity of the problem, the scenario of population ageing needs to be identified.

1.02: Population Ageing:

Population ageing or Demographic ageing refers to the changes in the age structure of a population. It is defined as the increase in the percentage of a population aged sixty years and older in a particular society[4]. This is associated with decrease in fertility and mortality. Population ageing has shown a significant impact on every society. Its' accelerating pace and ramifications to society termed this to be a phenomenon of

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1 Chakroborthy, R.(2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publications. p.25.

2 United Nations.(1998). World Population Projections to 2150. New York.

3 Bose. A and Kapur, M.(2004). *Growing old in India: voices reveal; statistics speak.* New Delhi: B.R Publishing Corporation. pp.3-4.

4 Sherlock.L.P. (2004).*Ageing, development and social protection.*In Sherlock. L.P. (Eds.). Ageing, development and social protection. London: Zed Books Publication. p.1.

global concern[5]. It is long established in developed countries and is now occurring in many poorer parts of the World.

Unlike biological ageing which is specific to each individual, Population ageing is a collective phenomenon. It results from a decrease in fertility and from a lengthening of the average length of life. On considering its impact on the age pyramid, it was noticed that the former causes "top-down" ageing i.e. the pyramid grows longer and wider and the later causes "bottom-up" ageing i.e. the base of the age pyramid grows narrower.

Population ageing is caused due to migration, longer life expectancy and decreased birth rate. It is both part of and influenced by wider processes of development and transformation like better health services, accessibility of advanced technologies etc.[6]

On looking into its impact, it was found that the rise of ageing population affects the demography of the labour market, patterns of consumption and production, trends of savings and investments, priorities in public spending, and delivery of social services. It is also responsible for the major changes in role, status, health and personal independence[7]. Thus it is essential to determine its policy implications which require a prior knowledge of the indicators of population ageing.

1.04: Indicators of Population Ageing:

Indicators of Population Ageing[8] are used to determine the extent and nature of population ageing in a country. Generally, the following indicators have been used to determine its trends:

1. Head Count Ratios
2. Statistical measures of Location
3. Percentiles or Population Pyramids

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5 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. p.34.

6 Ibid

7 Atal, Y. (2001).*The United Nations and Ageing.*In Modi, I. (Ed.). Ageing and human development: Global Perspectives.New Delhi: Rawat Publication. p.3.

8 www.wikipedia.org

1. Head Count Ratios: It includes the following ratios under its gambit:

a) Elderly Dependency Ratio:

It is the ratio of the elderly dependent population to the economically active population .It is also known as the old-age dependency ratio or age-dependency ratio. It can be classified as the number of individuals of retirement ages (65 and over) compared to the number of those of working ages. For convenience, working ages may be assumed to start at age fifteen, although increasing proportions of individuals pursue their education beyond that age and remain, meanwhile, financially dependent, either on the State or on their parents. This ratio is used to assess intergenerational transfers, taxation policies, and saving behaviours.

b) Elder-Child Ratio:

Another indicator of the age structure is the ageing index or the elder-child ratio. It is defined as the number of people aged 60 and over per hundred youths under age of fifteen. Important to note here is the fact that in 2000, only a few countries including Germany, Greece, Italy, Bulgaria, and Japan had more elderly than youth (i.e. ageing index is above 100), whereas by 2030, the ageing index is projected to exceed 100 in all developed countries and even expected to exceed 200 in several European countries and Japan.

Hence, all these indicators of population ageing are simply relating the number of individuals; whereas, they fail to take into account the age-distribution within the large categories among the elderly i.e. the young-old, old-old and the oldest-old age group. Further health, financial situation, and consumption patterns may vary greatly between a person aged sixty five years and eighty years. Hence, simple ratios conceal important heterogeneity in the elderly population. In order to combat this difficulty the other measures of locating population ageing were considered which are discussed as follows:

2. The Statistical Measures of Location:

It includes the median and mean age of a population.

a) Median age:

It is defined as the age at which exactly half of the population is older and another half is younger. It is one of the most widely used indicators of Population ageing.

b) Mean age:

It is simply the average of old age population of a country and is very sensitive to changes in the age distribution. Because of this advantage, it is always preferred over the median age in studying the dynamics of population ageing.

3. The Percentiles or graphs: It includes the population pyramids.

a) Population pyramids:

The most adequate approach to study population ageing is demographic determinants i.e. population pyramid. Population pyramid is named for the pyramidal shape of its graph. A population pyramid also called age-sex pyramid and age-structure diagram. It is a graphical illustration that shows the distribution of various age groups in a population (typically of a country or region of the world), which normally forms the shape of a pyramid. Demographers commonly use population pyramids to describe both age and sex distribution of populations. Youthful populations are represented by pyramids with a broad base of young children and a narrow apex of older people, while older populations are characterized by more uniform numbers of people in the age categories[9].

1.03: Demographic Transition:

Demographic transition began about two decades ago as a scapegoat for changes in society and the economy that have non demographic causes[10].Thompson was the first person to talk about demographic transition and now it becomes so much crucial that even the United Nations Demographic year book of 1993 puts the 'demographic transition' at the centre stage[11]. In actual, demographic transition is a shift from one stage to another where each stage represents a pattern of population growth.

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9 www.galegroup.com

10 Mullan. P.(2002). *The Imaginary time bomb: why an aging population is not a social problem.* London : Taurus Publishers. p.6.

11 Ibid, p.30.

Demographic transition is based on the birth and death rate of a nation and thus it determines the population structure.

Demographic Transition is associated with broader processes of modernization and development. It is a positive expression of human development and progress. This happens in two ways. First, elderly people themselves tend to live longer as a result of the curbing of wide scale fatal diseases and illnesses. Second, is the fall in fertility because with fewer younger people the average of population rises and society ages[12].Modern day transition theory classified the following stages of demographic transition (table 1.01):

Table 1.01: Stages of demographic transition

Stage of Transition	Life Expectancy at Birth (In Years)	Total Fertility Rate(TFR)
Stage I	< 45 yrs	> 6.0
Stage II	45 to 55 yrs	4.5 to 6.0
Stage III	55 to 65 yrs	3.0 to 4.5
Stage IV	65 >yrs	< 3.0

Source[13]

Stage I of demographic transition signifies a stage of little or no population growth. In this stage both the birth and death rates are high. This stage was more prevalent in the pre-industrial society i.e. before seventeenth century.

Stage II of demographic transition is the stage of rapid population growth where death rate is low while birth rate continues to remain high. This stage is the result of modernization and it was observed that countries can't remain in this stage for a longer duration.

Stage III of demographic transition is further subjected to modernization and development. In this stage, fertility is subjected to deliberate control whereas the birth rate starts to decline. At this stage, the growth rate is somewhat controlled.

Stage IV is a stage of zero growth rate of population. This is an ideal stage because population size stabilizes. Hence, this stage is difficult to attain. Generally, countries

12 Ibid, p. 26.
13 Chakroborthy.R.(2004). *The Greying of India: Population Ageing in the context of Asia,* New Delhi: Sage Publication. p.90.

with growth rate below 0.4 can be considered to have attained a stable population growth.

India is presently having life expectancy at birth as 64.8 years (census, 2001) increased to 66 years in 2010(Global age watch data, help age)[14] and TFR as 3.2 (census, 2001) which further reduces to 2.6 during 2009[15] (office of registrar general, 2011 data) and hence it is in stage III of demographic transition. But sooner it will enter into the stage IV which is already experienced by many of the developed nations.

At this stage the following features of demographic transition have been observed:

- Growth rate of elderly is higher than the general population.
- Number of female elderly is more than males.
- Life span after retirement is five times more than what it was at independence.
- At age sixty and over, proportion of widows are more than widowers.

Hence, from above it looks that in years to come this demographic transition along with increase in longevity would generate enormous challenges for ageing in India.

1.05: Interface between Demographic Transition and Population Ageing:

Population ageing is one of the significant by-products of Demographic transition. Population ageing is a phenomenon characterized by decline in fertility levels and continued increase in the levels of life expectancy. These two variables are producing fundamental changes in the age structure of the population and hence mark the "demographic transition". After reaching low levels of both mortality and fertility; population ageing typically occurs[16]. Thus population ageing is a stage or rapidity of demographic transition that determines the population ageing process.

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14 www.helpage.org/global-agewatch/population-ageing-data

15 www.censusindia.gov.in

16 Bhawsar, R.D. (2001). *Population ageing in India: Demographic and health dimensions*. In Modi, I. (Ed.). Ageing and human development: Global perspectives. New Delhi: Rawat Publication. p. 256.

In simple terms, population ageing is usually associated with the final stage of demographic transition which involves sustained falls in fertility and smaller numbers of younger age groups[17].

Further, with the advent of demographic transition, population ageing is becoming a serious problem in almost all societies. It is irreversible unless the old demographic situation of high fertility and high mortality is achieved. It will affect all the World's countries in future, and will be faster in the countries of the South as compared to the North[18]. It is even more prevalent in developing countries. Therefore, it becomes imperative to understand the scenario of population ageing in detail so that the coming generations would not consider it as a catastrophe.

1.06: Scenario of Population Ageing: Global to Local Perspective

A. Global Scenario:

At the global level, the phenomenon of ageing was first highlighted in 1982 when the United Nations organized the first World Assembly on Ageing in Vienna[19].The assembly highlighted two striking aspects of global ageing: rapid speed and high magnitude.

The 'rapid speed' with which ageing is occurring in both developed and developing nations can be analyzed by the fact that while in developed nations, like France, it took 115 years to increase the percentage of aged from seven to fourteen percent (i.e. b/w 1865-1980); in Japan, it has taken twenty six years (i.e. b/w 1970-1996); whereas, in many of the developing countries like Jamaica, only 18 years(i.e. b/w 2015-2033) are expected as sufficient to double the ageing population from seven to fourteen percent. However, in Tunisia, the same will be expected to accomplish in just fifteen years [20](i.e. b/w 2020-2035).Hence, speed with which the ageing population is increasing is definitely a serious concern for all nations.

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17 Chakroborthy, R.(2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication. p.101.

18 www.citesciences.fr

19 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. P.13.

20 Atal, Y. (2001). *The United Nations and Ageing.* In Modi, I. (Ed.). Ageing and human Development : Global perspectives. New Delhi: Rawat Publication. p.5.

Further, the 'magnitude of ageing' can be analyzed simply by looking into the fact that in 1950, only three countries had more than one million aged Population, namely, China, India and U.S.A. In 2000, Japan and Russian Federation joined the list. By 2050, thirty-three countries are expected to be on the list of ageing nations[21].In addition, many national and international bodies working continuously for identifying the magnitude and consequences of population ageing highlighted the increase in ageing population in the overall share of the World's population e.g. The U.N. Population Division projected the following trends in population growth of the World.

Table 1.02: Population Projection of aged in the World; 1995-2150

Year	Total population (in billions)	Percentage of aged(60+)	Percentage of aged(65+)	Percentage of aged(80+)
1995	5.68	9.5	6.1	1.1
2000	6.07	9.9	6.8	1.1
2025	8.03	14.6	10.8	1.7
2050	9.36	21.1	15.1	3.4
2075	10.06	24.8	19.1	5.3
2100	10.41	27.7	22.0	7.1
2150	10.80	30.5	24.9	9.8

Source:[22]

The above table clearly signifies the fact that in decades to come, there will be more elderly persons as the aged population will show a significant rise by 2050 i.e. become ten percent of the World population. In fact, the population of elderly will outnumber the population of children.

It is therefore, predicted that in near future virtually all countries of the World will face the impact of population ageing. However, significant differences were observed between different regions and also between different countries. For instance, the United Nations Population Projections (Table 1.02) place the likely proportion of aged in the developed countries as twenty seven percent of total population by the year 2025

21 Chakroborthy, R. (2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication. p.13.

22 Saxena, D.N. (1988). *Senior Citizens: Their problems and potentialities.* In Gangrade, K.D and BoseA.B. (Ed.). The Ageing in India: problems and potentialities.New Delhi: Abhinav Publications. p.87.

against 12.3 percent reported for developing countries[23].Europe was reported as the World's oldest region followed by North America and Asia. Likewise, Africa was reported as the World's youngest region.

TABLE 1.03 – Population Ageing in the Major Regions of the World

Region	Percentage of aged 60 years and above in different time phases			
	1950	2000	2025	2050
World	8.1	9.9	14.6	20.7
Most developed regions	11.7	19.3	27.0	31.2
Less developed regions	6.4	7.6	12.3	19.2
Least developed region	5.4	4.8	6.2	11.6
Sub-Saharan Africa	5.0	4.7	5.8	10.6
Africa	5.1	5.0	6.5	11.8
Asia	6.7	8.7	14.4	21.9
Europe	12.1	20.1	27.3	32.8
Latin America	6.0	8.0	14.1	22.2
Northern America	12.4	16.4	25.0	27.4

Source:[24]

In another projection, UN reported that amongst the World's oldest countries aged sixty five and over, top twenty are all European (except Japan). The proportion of elderly in Southern Europe is expected to reach 37.2 percent by 2050 as from 21.5 percent reported in 2001. Globally, Italy has the highest proportion of persons aged sixty five years and over (18.2 %) followed by Japan (17.7 %), Greece (17.3 %), Sweden (17.2 %) and Spain (16.4 %)[25].

Not only developed countries; the number of elderly in the developing countries are also experiencing growth at a phenomenal rate. According to the World Bank estimate (1994), by 2025, almost seventy percent of the World's elderly will live in developing countries[26].Another estimates shows that in developing countries every twelfth person is now elderly and the ratio is expected to become one in five by

23 Ibid.
24 Ibid.
25 Harper, S. (2006).*Ageing Societies: myths, challenges and opportunities.*NewYork: Oxford University Press. p.4.
26 Bagga, A.andDayabati D. S. (2006). *Ageing in women.*New Delhi: Mittal Publications. p.12.

2050.Similarly, in the develop countries the ratio is projected to reach one in three by 2050[27]. Thus most of the growth of elderly persons will take place in developing countries and over half of it will be in Asia. Hence, it was rightly quoted that "the developed nations of the West had become 'rich' before they become 'older' but developing countries are becoming 'older' before they become richer"[28].

B. Asian Scenario of Population Ageing:

Population Ageing is of serious concern for all Asian countries because the growth of older population in these countries is much more rapid as compared to the developed nations. Furthermore, ageing would accompany an increasing degree of population feminization as death rates for females tend to be significantly lower than those for males.[29]

Very soon Asian countries will experience the consequences of population ageing. For instance, it took eighty two and one hundred fourteen years respectively; for the population aged sixty five years and above to get double from seven to fourteen percent in France and Sweden. However, Bangladesh, China and Pakistan will make this transition within a frame of just twenty five to twenty eight years. This rapid change in age structure will be more difficult for Asian countries to adjust because of shorter time frame[30].

In Asia, as a whole, every eleventh person is sixty plus. By 2050, every fourth person will be an elderly and in the next fifty years; every fifth among them would be over eighty years of age. It is further expected that most Asian countries except Yemen, Nepal, Bangladesh, Afghanistan and East Timor would attain the double digit figure in ageing population by 2050.Though Asia as a whole accounts for only nine percent of the World's elderly; there are variations among the different regions as shown in Table 1.04[31].The table clearly indicates that Eastern Asia was leading in the number

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27 Rajan, I.S. et.al. (2003). *Foundations of ageing in India: Demography of Indian ageing.* In Phoebe. S.L.(Eds.). An aging in India: perspectives, prospects and policies. NewYork: Haworth Press. p.14.

28 Awin, N. (2006). *The role of Government in health and ageing: experiences of Malaysia.* In Prakash, I.J.(Ed.). Ageing with Health and Dignity: Proceedings of the Asian Regional Conferences. 9th to 11th Feb. Deptt.of Psychology. Bangalore University Press.p.2.

29 Chakroborthy, R. (2004).*The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication. p.22.

30 Bose.A and Kapur.M.(2004). *Growing old in India: voices reveal; statistics speak.* New Delhi: B.R Publishing Corporation. p.4.

31 Ibid.

of aged population in Asia by touching eleven percent mark in 2000 followed by South Eastern, South Central and Western Asia.

TABLE 1.04 Population ageing in Asia; 1950-2050 Projections of United Nations

S.No	Country	Percentage of aged sixty and above			
		1950	2000	2025	2050
1.	Asia	6.7	8.7	14.4	21.9
2.	Eastern Asia	7.4	11.0	19.6	26.9
	China	7.5	10.0	18.5	26.2
	Hong Kong	3.7	15.0	32.4	38.9
	Japan	7.7	22.6	32.1	36.0
3.	South Central Asia	6.1	7.0	11.3	19.5
	Afghanistan	3.4	4.6	6.1	9.9
	Bangladesh	6.2	5.2	9.0	19.9
	Bhutan	5.8	5.2	6.3	10.6
	India	5.6	7.6	12.6	21.3
	Nepal	5.7	5.8	7.1	10.2
4.	South Eastern Asia	5.9	7.2	12.5	21.2
	Singapore	3.7	10.4	27.8	29.1
	Thailand	4.8	8.7	17.9	28.1
	Vietnam	6.5	7.3	11.9	22.1
5.	Western Asia	7.1	7.1	10.7	17.0
	Bahrain	4.6	4.9	19.6	24.3
	Cyprus	9.1	15.3	22.3	26.1
	Israel	6.3	12.7	18.1	24.4
	Kuwait	4.5	3.6	16.0	24.7

Source:[32]

Further by 2050, one in four in Eastern Asia, one in five in South Asia, Central Asia and Eastern Asia and one in six in Western Asia are expected to be on the list of

32 United Nations.(1998). World population prospects (1950-2050) in S.I. Rajan and P.S.Sarma et.al. (2003) in *'foundations of Aging in India: Demography of Indian Ageing'*. In Phoebe S. Liebig. (eds.).An aging in India; perspectives, prospects and policies. New York: Haworth press, p.15

elderly generation. Presently, seven countries in Asia have crossed the ten percent mark and Japan is one which has already crossed twenty percent mark. Hence, it is projected that by 2050, the proportion of elderly persons in all the countries in Asia, except Afghanistan, Oman and Yemen, is projected to be above ten percent mark.

Further amongst the Asian countries, the two most populous countries in the World, namely, China and India; may never be forgotten. It was supposed that by 2050; both India and China will share the major proportion of the World's elderly. Currently, one in ten Chinese and one in twelve Indians is an elderly and this ratio is expected to reach one in four and one in five by 2050. In absolute terms, India's elderly population is expected to increase from 76 million in 2000 to 32.7 million in 2050, and that of China from 127 million in 2000 to 397 million by 2050[33]. On looking into these alarming signals, the clear understanding of the ageing phenomenon and population pattern along with a long term planning is required.

C. Indian Scenario of Population Ageing:

In India, like many other developing countries, the problem of population ageing is becoming highly visible and pressing. It is surely going to become a challenging issue as every minute about twenty three Indians joined the rank of "elderly". Statistically, population ageing refers to the increasing proportion of population above sixty years of age in the overall age structure of the population[34].The proportion of elderly persons in India has increased from 5.63 percent in 1961 to 7.7 percent in 2001 (Table 1.05 and 1.06).

Table 1.06 reflects the feminization of ageing as a notable aspect of the ageing process. Till 1991, both the genders showed uniformity, whereas in 2001 many States represented much higher ageing tendencies among the females as compared to the males. It is further estimated that by 2016, the percentage of elderly female population will surpass those of elderly male in the total share of population (i.e. 9 % against

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33 Rajan, I.S. (2003).*Demography of ageing*. In Dey, A.B.(Ed.). Ageing in India: situational analysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited.p.4.

34 Prakash, I.J. (2001). *On being old and female: some issues in QOL of elderly women in India*.In Modi, I. (Ed.). Ageing and human development: Global perspectives. New Delhi: Rawat Publication. pp.333-341.

8.8%) and this trend will be experienced by the majority of States[35]. For India, feminization of ageing is a cause of concern rather than a cause for celebrations. This is due to the predominant patriarchal ethos making the older women face 'triple jeopardy' that of being female, of being old, and of being poor[36].

Table 1.06 also reveals the 'region-wise' distribution of elderly and figured South India as the region with highest number of elderly persons and will be expected to lead in the next forty years. In fact, one-fourth of India's elderly persons live in Southern part, whereas, Central India scored the second highest position followed by East India and North-East India[37].Among the South Indian region; 'Kerala' was found to be a State with highest proportion of elderly (8.77% in 1991 and 10.5% in 2001) and the lowest was observed in Andaman and Nicobar Island (3.55% in 1991). Although no State or Union Territory is expected to have more than ten percent of elderly population at present; about seventeen of these are projected to have more than ten percent in the near future[38].Trends in the absolute number of elderly (60+) in India and major States figured Uttar Pradesh as the State with highest number of elderly population (9 million) followed by Maharashtra (5.5 million) and Madhya Pradesh (4.3 Million) out of the total of 76 million elderly population (census of India, 2001). Thus every State, irrespective of its present stage of demographic transition, is following and is projected to follow the course of transition in their age structure.

Thus it could be concluded that population of elderly is growing everywhere. It is no longer an exclusive characteristic of industrialized societies. India is also heading towards the similar demographic pattern like others. Today every sixth person in the World is an Indian and every fifteenth Indian is likely to be an older person[39] .The population of older persons in India ranks fourth highest in the World and by the end of the present century, it will be second only to China. Thus India can not only boast

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35 Bhawsar, R.D. (2001). *Population ageing in India: Demographic and health dimensions.* In Modi, I. (Ed.). Ageing and human development: Global perspectives. New Delhi: Rawat Publication. p.262.

36 Ibid.

37 Johnson, P. (2004). *Long term historical changes in the status of the UK as an exemplar of advanced Industrial economics.* In Sherlock, L. P. (Eds.). Ageing, development and social protection. London: Zed Books Publication. p.26.

38 Bagga, A. and Dayabati, D. S. (2006).*Ageing in women.* New Delhi: Mittal Publications. p.12.

39 Prakash, I. J. (Ed.). (2007). *Aging: Strategies for an active old age.* Vol. 7.Aging and Development Project. CCR-IFCU Publications.p.69.

of being the highly populous country, it can also claim a place among the "Aging nations".

The U.N declared India as an "ageing society" where the aged account for more than seven percent of the total population of the World[40].According to an estimate[41] there are at present 76 million aged persons in the country. Of this, sixty three percent are in the age group of 60 to 69 years and are called 'young- old', twenty six percent in 70 to 79 years group and described as 'old-old' and the remaining eleven percent are above eighty years of age and called 'oldest- old'. Rural-urban comparison of aged in India reveals the fact that about four-fifth of the aged in India are concentrated in rural areas i.e. about seventy eight percent of total ageing population. Thus India is sitting at the threshold of an ageing society where the aged population is subjected to increase at a much faster rate.

Table 1.05 – Percentage share of elderly in India and Major States

States	Total Population of Aged in Different Time Phases (in Percent)						
	1961	1971	1981	1991	2001	2011	2016
India	5.63	5.96	6.32	6.70	7.50	8.10	8.90
A.P	6.23	6.36	6.65	6.78	7.60	9.25	10.5
Bihar	5.61	5.90	6.80	6.25	6.60	6.50	6.50
Gujarat	4.95	5.27	5.34	6.40	6.90	6.60	7.90
Haryana	_	5.73	6.30	7.72	_	6.60	7.30
Karnataka	5.73	6.17	6.62	6.99	7.70	8.60	9.20
Kerala	5.83	6.22	7.49	8.81	10.50	11.5	12.8
M.P.	5.09	5.79	6.46	6.64	_	6.90	7.30
Maharashtra	5.22	5.72	6.39	6.99	8.70	8.40	9.40
Orissa	5.66	6.02	6.39	7.20	8.30	8.30	8.45
Punjab	6.50	7.42	7.76	7.82	9.0	7.40	8.05
Tamil Nadu	5.60	5.70	6.41	7.45	8.80	11.4	13.1
U.P.	6.28	6.75	6.82	6.84	7.0	6.55	6.70
WestBengal	_	5.37	5.56	6.05	7.10	8.45	9.60

Source:- [42]

40 Thomas, C. J. and Diengdoh, T. F. (2007). *Project report on ageing in Meghalaya.* Meghalaya: ICSSR North Eastern Regional Centre. Shillong.(Unpublished Research Thesis).p.3.

41 Rajan. I. S. et. al. (2003).*Foundations of ageing in India: Demography of Indian ageing.* In Phoebe S. L. (Eds.).An aging in India: perspectives, prospects and policies. New York: Haworth press. p.18.

42 Census of India (1961, 1971, 1981, 1991) Social and Cultural table.Registrar General of India. NewDelhi InBhawsar, R. D. (2001). *Population Ageing in India: Demographic and Health Dimensions.* In Modi, I.(ed.). 2001. Ageing and human development: Global perspectives. New

Table 1.06: Gender-wise share of elderly in India and Major States;1961-2016

States	Total Population of Aged Men and Women in Different Time Phases (in Percent)											
	1961		1971		1981		1991		2011		2016	
	M	F	M	F	M	F	M	F	M	F	M	F
India	5.46	5.8	5.94	5.99	6.23	6.41	6.69	6.71	8.0	8.2	8.8	9.0
A.P.	6.10	6.37	6.31	6.42	6.48	6.82	6.64	6.93	9.0	9.5	10.3	10.0
Bihar	5.14	6.0	5.74	6.06	6.77	6.83	6.53	5.97	6.8	6.2	7.3	6.8
Gujarat	4.52	5.3	4.97	5.57	5.52	5.16	5.96	6.84	6.3	7.9	6.9	8.9
Haryana	_	_	6.5	4.97	6.87	5.73	7.43	8.01	6.9	7.3	6.7	7.9
Karnataka	5.63	5.84	6.4	5.94	6.46	6.79	6.8	7.18	8.5	8.8	9.6	9.8
Kerala	5.65	6.02	5.97	6.47	7.15	7.84	8.33	9.29	10.8	12.2	12.1	13.0
M.P.	4.46	5.74	5.45	6.14	6.09	6.83	6.51	6.77	6.7	7.1	6.9	7.7
Maharashtra	5.01	5.54	5.52	5.93	6.07	6.72	6.69	7.3	7.8	9.0	8.7	10.0
Orissa	5.15	6.18	5.76	6.28	6.13	6.66	7.18	7.23	8.1	8.5	8.6	9.3
Punjab	7.27	5.73	8.22	6.63	8.28	7.25	8.07	7.58	6.8	8.0	7.3	8.8
Tamil Nadu	5.6	5.6	5.78	5.7	6.52	6.3	7.65	7.25	1.3	11.5	12.9	13.0
U.P.	6.3	6.27	6.99	6.57	7.05	6.6	7.22	6.46	6.3	6.8	6.3	7.1
West Bengal	_	_	5.03	5.61	5.32	5.81	5.93	6.17	8.5	8.4	9.7	9.5

Source:[43]

Aged sector today is the fastest growing sector of our population. In India, ageing of population is primarily the result of two factors- reductions in fertility and mortality. The reduction in mortality rate implies a longer life span for the individuals whereas the reduction in fertility implies a decline in the proportion of the young in the total share of population[44]. Generally with declining mortality, longevity increases .But the percentage in various age groups tends to remain constant if the birth rate remains the same. In actual, it was reported that with declining mortality, birth rates start falling and after a time lag leading to enormous changes in the age structure. The decline in the population of children from 31.3 percent in 1995 to 20.5 percent in 2050 and

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Delhi: Rawat Publicatian. pp. 260-261. and Census of India, 2001. (2006). *Age data available on CD from RGI office.GoI.* In Alam, M.Ageing in India: Socio-Economic and Health Dimension. New Delhi: Academic Foundation. p.74. and Population projection for 2011 and 2016. *The report of technical group on population projection, RGI.* New Delhi, 1996.In Bhawsar, R. D. (2001). *'Population Ageing in India: Demographic and Health Dimensions'.*In Modi, Ishwar. (ed.). 2001. Ageing and human development: Global perspectives. New Delhi: Rawat Publication. p.262.

43 Ibid.

44 Raju, S. S. (2000). *Ageing in India: an overview.*In Raju, S. S. and Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p.26.

increase in the population of aged from 5.68 percent in 1995 to 10 percent in 2050 is a result of this change.

These days the period of old age lasts a long than was seen mere two decades ago. With increase in life expectancy from forty years in 1951 to sixty four years today, a person today has twenty more years to live than he would have fifty years back[45]. Thus the major factor contributing to the changing demography is increased life expectancy. The advancement in medical sciences and improvement in health services is also responsible for this.

By 2050, the life expectancy at birth will expected to become eighty-two years in more developed nations, seventy-five years in less developed nations and seventy years in least developed nations[46]. No doubt, this unplanned increase in longevity would bring with it the problems of overcrowding, unemployment, under nutrition and sub-standard life-styles. For individual, the longer life span would bring changes in his social and economic World. In fact, it alters the basic requirements and life style of the elder generation. With older people living longer, the households are also getting smaller and congested, causing stress in joint and extended families. Even where they are co-residing marginalization, isolation and insecurity is observed among the older persons.

Hence, population ageing is a cause of concern for all nations may it developed or developing. In order to make an in depth analysis of its consequences, it is therefore required to know the basic concepts of ageing and its recent trends. Foremost is the concept of demographic transition and population ageing.

1.07: Recent trends of Population Ageing:

Many studies have been conducted to identify the recent trends of population ageing. The following trends have been identified thereof:

- **Population ageing is unprecedented and enduring:** Population ageing is not an event of past. It persists, remains and will continue in future. It is even more rapid

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45 Soneja, S. *Elder Abuse in India.* Country Report for World Health Organization. Help Age India. New Delhi. p.4.

46 Atal,Y.(2001). *The United Nations and Ageing.* In Modi, I. (Ed.). Ageing and human development: Global perspectives. New Delhi: Rawat Publication. p.5.

in present time. The growth rate of elderly has tripled over the last fifty years and this number is further expected to triple in the next fifty years[47].

- **Population ageing is pervasive:**

Population ageing is a global phenomenon affecting every nation though its impact may vary amongst different countries observing different stages of demographic transition.

- **Population ageing is fastest among the oldest-old age group:**

Population ageing is fastest among the oldest-old age group. Even though the population of aged sixty and over as a whole is increasing at a phenomenal rate but the 'oldest-old' are found to be the fastest growing segment of the elderly population[48]. In India alone, the aged population (60+) is about to touch 177 million mark by 2025, of whom, about twenty five percent would be above eighty years of age[49]

- **Feminization of population ageing:**

Population ageing is particularly rapid among women, resulting in "feminization of population ageing" .This is because of the lower mortality rates among the women. This trend is even more visible in developed nations as compared to the developing one. For instance, In the United States[50], there were about 20.6 million elderly women and 14.4 million elderly men in 2000 i.e. having a sex ratio of 143 women for every 100 men. In India, similar trends will be expected by the year 2016 when number of females outnumbers males [51](i.e. 9 % against 8.8 %).

- **Population ageing has profound implications:**

Population ageing has profound implications in many facets of human life. It leads to breaking up of family ties, unemployment, and lower income, under nutrition, poverty

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47 Chakroborthy, R. (2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication. p.34.

48 www.galegroup.com

49 Thomas, C. J. and Diengdoh, T. F.(2007). *Project report on Ageing in Meghalaya.* ICSSR North Eastern Regional Centre, Shillong. Meghalaya and Directorate of Social Welfare. Government of Meghalaya. Shillong (Research Thesis). p.3.

50 www.galegroup.com

51 Prakash; I. J.(2007). *Aging: Strategies for an active old age.*Vol. 7. Aging and Development Project.CCR-IFCU Publications. p.69.

and substandard life styles. It was reported that over 100 million older people live on less than a dollar a day[52].

- **Most of the World's elderly lives in developing countries:**

Though currently the most developed regions of the World have relatively high proportions of the elderly, the older population is concentrated in the less developed regions and is growing at a much faster rate[53].Even in the poorest countries, life expectancy is increasing and the number of older people is growing. In 2000, there were 374 million people over 60 in developing countries representing sixty two percent of the World's elder population. By 2015; this could increase to about 597 million i.e.67% respectively[54].

Therefore, in the light of these trends, it could be inferred that population ageing is a universal phenomenon. It is inevitable and hence every nation irrespective of its pace of development, must inculcate ageing in its research agenda. Further, if countries want to celebrate ageing of its citizens; they must understand the implications of population ageing.

1.08: Implications of population ageing:

Population ageing has established itself as the most pressing problem of developed economies. The developing countries of Asia are not far behind either. While population ageing represents, in one sense, a success story for mankind; it also poses profound challenges to public institutions that must adapt to a changing age structure[55].The ageing of population has many profound social and economic implications. Recently, many countries have been conducting academic and policy debates on the implications of demographic ageing.

A key economic issue for policy makers is the provision of social security benefits to its senior citizens. One such issue is the 'pension and care' challenge. This challenge

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52 Awin, N. (2006). *The role of government in health and ageing: experiences of Malaysia*. In Prakash, I.J. Ageing with Health and Dignity: Proceedings of the Asian Regional Conferences. 9th to 11th Feb. Dept. of Psychology. Bangalore University Press.p.1.

53 Bakshi, R. et. al. (2007).*Problems of the Aged living with families and in senior citizens homes: A comparative study*. In Indira, J. P. (Ed.).Aging strategies for an active old age.7th volume of the Aging and Development Project.CCR-IFCU Publications.p.68.

54 www.helpage.org

55 www.galegroup.com

is even more difficult for underdeveloped and developing nations as it places a strong pressure on their social security programs. This has prompted them to alter social protection systems like cuts in benefits, tax increments, massive borrowing, lower cost of living adjustments, later retirement ages, or a combination of these elements. Further the rise in 'old age dependency ratio' would decline the proportion of working population which in turn creates social and political pressures on social support systems.

Population ageing is also a great challenge for the health care systems. As nations age, the prevalence of disability, frailty, and chronic diseases is also expected to rise significantly. Moreover, the changes in traditional pattern of care giving due to the participation of women in labour force make the policy makers to plan for formalized system of care-giving. It further enhances the problem of policy makers.

Implications of population ageing are increasingly important at the regional level. Important questions to be answered concern how the variable regional dimensions of population ageing should be incorporated in the design and delivery of ageing policy strategies, in the allocation of finance, choice of policy instruments and delivery mechanisms. The new policy areas now incorporated into the ageing agenda imply the need for multi-faceted and multi-level policy approach.

To date, research about population ageing, particularly in low and middle income countries, remain underdeveloped and patchy. Views labeling older people as inherently incapable, as well as representing a burden on public policy and informal cares are more often based on supposition than hard evidence, and there are increasing calls for a more up-beat, "active-ageing" approach. Population ageing requires a dynamic response from public policy and social attitudes[56].Policy responses to demographic ageing are recognizing the huge diversity of the wealth and inclusion of older people. The reform of labour markets to promote job creation and increased productivity among the older people also requires accompanying policies to counter discrimination, improve social protection, gender equality and minority rights.

Implications of population ageing are increasingly important at the regional level. The more sophisticated conceptualizations being developed by academicians and the new

56 Sherlock, L. P. (2004). *Ageing, development and social protection.* In Sherlock. L. P. (Eds.). Ageing, Development and Social Protection. London: Zed Books Publication. p.15.

policy areas now incorporated into the ageing agenda imply the need for multi-faceted and multi-level policy approaches that incorporate the regional dimension. Concern is to know that how do we incorporate 'regional dimensions' in the design and delivery of ageing policy in the allocation of finance, choice of policy instruments and delivery mechanisms. The design of new policy instruments must also take into account the need to interface at the work place level in order to encourage more progressive attitudes to older workers. Finally, to check the extent to which policy formulation and delivery includes co-operation with social partners; the direct involvement of older people is required.[57]

Regrettably, ageing has received only peripheral attention from development theorists and policy makers. They visualize ageing as a problem only in a long run[58]. This may not be true .There is an urgent need for a stronger knowledge base and for developing coherent policy framework which addresses the effects of ageing and the needs of older people.

Population ageing brings both challenges and opportunities. It brings a challenge in finding new ways of dealing with each other, of communicating with the generations, of supporting each other for social integration. It is not necessarily a catastrophe for individuals, societies and their social systems rather, it serves as an opportunity to realize new potentials. But for this, a clear understanding of ageing phenomena is required.

1.09: Population Ageing vs. Individual Ageing:

'Population ageing' is often confused with 'individual ageing' although the two terms connotes different meaning. Ageing is a global phenomenon. It is not just an issue of the State, but also of society, family and most importantly; the individual. The demographic and socio-cultural trends have made ageing an issue of concern not only at national and global level but also at personal and experimental level.

At personal level, ageing connotes three distinct phenomenon's: the biological capacity for survival, the psychological capacity for adaptation and sociological

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57 www.ageconcern.org.uk

58 Chakroborthy, R. (2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication.p.230.

capacity for the fulfillment of social roles[59].At experimental level, social scientists are interested in two broader aspects of ageing. The first is how any society functions as an age structure and how changing age distributions over time affect economic, political and other aspects of social organization. The second is how attitudes and roles changes over the life cycle of an individuals or in cohorts of individuals[60]. Hence, when rise of ageing population at State, national and global level is considered we referred it as 'population ageing' and when we consider the individual changes in the life pattern of an individual we call it 'individual or human ageing'. In actual, there exists a cause-effect relationship between the two. Individual ageing is the cause whereas population ageing is the effect i.e. when individual ages, population ages.

Time to time, various attempts have been made in defining ageing associated with progressive changes in an individual. In simple words, ageing for an individual refers to the process of growing older with each moment of growing life. Functionally, ageing has been defined as a progressive loss of functions and capacities after the organism has reached maturity. According to A. Bagga[61], the word ageing is used in two ways. The simpler meaning is purely chronological and the second ascribes to many changes, which have taken place since physiological deterioration, some readily apparent, others not easily detectable. Thus the key factors in defining individual ageing are the 'process' and 'change' The changes occur in an individual as the result of the passage of time. These may be anatomical, psychological, physiological and even social. Ageing is thus defined in terms of changes.

Moreover, Ageing has different connotations for different group of people. For the politicians, bureaucrats, lawyers, doctors and capitalists, ageing may mean the accumulation of more wealth or the enhancement of power. For those in the middle class, ageing may mean forced retirement and dependence on pension, which continues to lose its worth due to inflationary pressures. For the poor and working class, ageing may mean a State of total dependence and abject poverty. Similarly, Ageing has different meaning for men and women. For men, it is considered where

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59 Richard. A. S. (2006). *Ageing and the Life course.* In Robert H. B. and Linda K. G. (Eds.).*Handbook of ageing and the social sciences.*6th Edn. Academic Press.p.14.

60 Neugarten, L.B. (1970). *The Old and the young in the Modern Societies.* In Shanas, E. (Ed.).Aging in Contemporary Society. London: Sage Publication. p.13.

61 Bagga, A. and Dayabati, D.S. (2006).*Ageing in Women.* New Delhi: Mittal Publications. p.2.

success and power compensate for loss of youth. For most women, ageing means the loss of physical charm, a highly valued aspect of their lives etc[62].

To conclude, ageing is a very imprecise concept which has distinct biological, social and psychological components. It is an indicator of many phenomenons; it can be an epi-phenomenon[63].

Ageing is even confused with old age. The following conceptualization clarifies this difference:

1.10: Conceptualization of the definition of "Old":

From time to time scholars have assigned different notions to the aged people as 'elderly', 'old', 'third age individual', 'individual in the twilight of life', 'forgotten generation' and 'senior citizen' etc. But there is noted a remarkable difference in the meaning of the term 'ageing' and 'aged'. The term 'aged' or 'elderly' refers to a section of population aged sixty and over whereas the term 'ageing' represents a continuous process of becoming old[64].'Old age' is the closing period in the life span, whereas 'ageing' is termed as a part of living which begins with conception and terminates with death[65].Traditionally, old age has been perceived as the stage of life when decrements outweigh increments, when capacities and opportunities declines and when the functional limitations that tend to be associated with advanced age present a significant handicap to the individual in relation to his/her desired roles in life[66].

Today there are many ways of defining 'old age' composed of an infinite number of overlapping points of view with respect to a given person. In the context of the International Plan on Ageing, the U.N. defines sixty years and over as "aged". However, W.H.O. defines elderly population as "people aged sixty five years and

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62 Soodan, K.S. (1975). *Ageing in India.*Calcutta: Minerva Associates Publications. p.7.

63 Sauvain, C. and Henri L. et al.(2006). *Human clocks: The Bio-cultural meanings of age, population, family and society.* Germany: Europian Academic Publishers. Bern. Vol.5. p.14.

64 Khan, A. M. (2005).*Empowerment of elderly- source of healthy ageing.* In Prakash, I.J. (Ed.). Ageingin India: retrospect and prospects. CCR-IFCU.Project Report on Ageing and Development.p.141.

65 Pappathi, K. (2007). *Ageing: Scientific Perspective and Social Issues.* New Delhi: A.P.H. Publishing Corporation. p.9.

66 Mohanan, P. and Sajjan, B.S. (2005). *Problems of The Aged: A Multi Dimensional Approach.* In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU.Project Report on Ageing andDevelopment.p.72.

over"[67]. Government of India adopted 'National Policy on Older Persons' in January, 1999 to define 'senior citizen' or 'elderly' as a person who is of age 60 years or above.[68]

Old age has different meanings in different contexts. The difference further varies with culture or society in which one grows older. For instance, in rural areas, old age is identified as a period of life when a slide from independence to dependency on others will take place. This slide may arise due their poor health and increased age. Among peasant communities, handing over of property by an ageing individual to others belonging to the younger generation symbolizes the crossing of the threshold of old age. Significant difference is also noted between men and women. For women, the transition to old age occurs with menopause and the contraction of domestic roles after the joining of daughter-in-law. For men, the role attrition starts with an easing of work activity and continues after retirement[69].

Old age is an ambiguous term. However, a variety of definitions have been offered in Gerontological literature, but there exist no clear cut demarcation of age upon the attainment of which a person can be called 'old' or 'aged'. Various scholars also highlighted the fact that it is really difficult to draw a dividing line uniformly to categorize the 'elderly'. According to N.K. Chadha[70], 'Old age is a relative concept'. A ten year old is likely to think of someone who is thirty year old as aged whereas, sixty five years old may think of those individuals who are seventy five years of age as aged.

Along with individuals; old age also varies between countries because of different social, economic and historical backgrounds. Even the academicians and researchers have difficult time in deciding when an individual becomes old. The problem in defining aged stem from the fact that researchers are using different criteria. Some distinguish and separate age groups on the basis of chronological age, others do so on the basis of their social, psychological or physiological characteristics. Thus, there

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67 Bagga, A. and Dayabati, D. S.(2006). *Ageing in women*.New Delhi: Mittal Publications. p.3.

68 Report on '*Situation Analysis of The Elderly in India*'. (2011) .Central Statistics Office Ministry of Statistics and Programme Implementation; Government of India. p.iii

69 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration*. Shimla: Indian Institute of Advanced Studies. p.43.

70 Chadha, N.K.(2003). *Urban ageing: Issues and challenges*. In Dey, A.B (Ed.). Ageing in India: situational analysis and planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.93.

exist many dimensions through which ageing can be measured. Few such dimensions are given below:

1.11: Dimensions of Human Ageing:

Ageing is an ambiguous term. Distinctions have been made between "universal ageing" (age changes that all people share) and "probabilistic ageing" (age changes that may happen to some, but not all people as they grow older). Distinction is also made between biological, social and psychological ageing. In general, gerontologists and social scientists classify the phenomenon of ageing under the following dimensions: Biological, Social, Psychological and Cultural. These dimensions are discussed as follows:

a. **Biological Ageing:** Biological ageing means the anatomical changes that occur within the organism[71]. It is seen as a complex of progressive changes in cellular composition, capacity for growth, in tissue structure and endurance of the neuro-muscular system and in the reduction in the capacity to integrate organ systems[72]. It occurs in the later part of the life of an individual and includes graying of hair; loss of teeth; diminishing of sight and audibility; general slowing down of all systems of the body; changes in sensory motor performances and muscle strength; brittleness of the skeleton structure, reaction time and balance; decrease in the bone mass; the loss of body hair; weakening of the voluntary muscles; rigidity of connective tissues; the slowdown of the body metabolism; occurrence of sleep problems; and higher threshold levels of all the senses[73].

   Biological ageing is not considered as the best marker of ageing as these changes are physiological in nature and may begin long before the individual reaches chronological age of sixty[74].Deterioration of the various parts of the body proceeds at different rates and is generally so slow that it can't be measured accurately on weekly, monthly and annual basis. Hence, one can't fix any age as

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71 Chattopadhyay, K. (2006). *The aged in suburban context: study in social gerontology*.ArambaghBook House. p.28.

72 Ibid, p.7.

73 Bagga, A. and Dayabati, D. S. (2006).*Ageing in women.* New Delhi: Mittal Publications. p.2.

74 Chadha, N.K.(2003). *Urban ageing: Issues and challenges.* In Dey, A.B. (Ed.).Ageing in India: Situational analysis and planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.93.

specific, where all physical functions of a given individual begin to show a decline.

Moreover, Biological ageing varies between societies, historical times and between people. This is due their social and economic background, their different ways of living and for psychological and medical reasons[75]. Changes do occur over the life course and hence an individual cannot be young forever[76].But such changes are more often conditioned by the States of nutrition, health ,housing and better employment facilities [77].Thus need is to plan all these facilities for the nation.

b. **Psychological Ageing:** Psychological ageing is seen in terms of changes in the central nervous system, in sensory and perceptual capacities and inability to organize and utilize information It consists of general decline in the mental abilities that accompany old age and the attitudes and behaviours of others towards the elderly[78]. It also refers to the adaptive capacities of individuals as observed from their behavior i.e. how well one adapts to subjective reaction or self-awareness, changing environmental conditions and with the society and how best one can lead himself/herself to higher thinking[79].Generally the behaviors that people use to adapt to changing environmental demands may include memory, feelings, motivation, intelligence, skills of fostering and maintaining self-esteem and personal control[80].

Psychological ageing leads to gradual loss in confidence, loss in self-image, self-esteem, questioning of own abilities, developing feeling of powerlessness, going into negativity and linking all physical problems with ageing. It further leads to changes in personality and external behaviours that consists of a general decline in the mental abilities of the aged. Hence, psychological ageing is related to

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75 Dandekar, K. (1996), *The elderly in India.* New Delhi: Sage Publications. p.2.

76 Mullan, P.(2002). *The Imaginary time bomb: why an aging population is not a social problem.* London: Taurus Publishers. p.15.

77 Tondon, S. (2006).*Senior citizens: Perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.6.

78 Chattopadhyay, K. (2006). *The aged in suburban context: study in social gerontology.* Arambagh BookHouse.p.7.

79 Chadha, N.K. (2003). *Urban ageing: Issues and challenges.* In Dey, A.B. (Ed.).Ageing in India: Situational analysis and planning for the future. Ministry of Health and Family Welfare. Rakmo Press Private Limited. New Delhi. p.93.

80 Ibid. p.96.

individual's State of mind[81]. It can be studied under different perspectives like decline in the intellectual capabilities, creative capabilities, personalities, potentialities, decrease of adaptive and survival skills and lack of flexibility etc. All these perspectives of ageing are based on the concept of "individual differences"[82].Psychological ageing, as observed, is a gradual process. Unlike physical ageing, it does not occur in days and months, it rather emerges gradually over the years.

Society and it's socio-cultural beliefs plays a magnanimous role in psychological ageing[83].Moreover, the psychological changes in respect of individual's concept of the self, his idea about his worth as an individual and as a member of social groups, his feelings about the attitudes and behaviours of others towards him and his general view of life and the World can all play a significant role in the process of psychological ageing[84].Therefore, a positive State of mind and continued interest in ageing process greatly help in reducing psychological ageing ,whereas, an unfavorable and negative attitude towards the changed physical and social conditions fastens the psychological ageing[85].

c. **Social Ageing:** The term 'social ageing' implies the process of becoming old according to the social roles played by the elderly. These roles are sets of expectations or guidelines for people who occupy given positions such as widow, retiree, grandfather etc.[86] The parameters of social ageing may vary in different contexts and in different societies. A person is considered 'old' when he is so regarded and treated by his contemporaries or cohorts and by the younger generation[87].

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81 Chengti. S. K. (2007). *Health status and longevity of the elderly.*In Prakash, I.J. (Ed.).Aging strategiesfor an active old age.7th volume of the Aging and Development Project.CCR-IFCU Publications.p.96.

82 Mullan, P.(2002). *The Imaginary time bomb: why an aging population is not a social problem.* London: Taurus Publishers. p.143.

83 Khan, A. M. (2005).*Empowerment of elderly- source of healthy ageing.*In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU.Project Report on Ageing and Development.p.141.

84 Mishra, G. (1997). *Ageing: The people's concern.* In Husain, M.G.(Ed.). Changing Indian society and status of aged. New Delhi: Manak Publications. pp.137-149.

85 Tondon, S. (2006).*Senior citizens: perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.7.

86 Quadagno, J. (1999). *Aging and the life course: An introduction to social gerontology.* Tata Mc. Graw Hill.p.10.

87 Chattopadhyay, K. (2006). *The aged in suburban context: study in social gerontology.* Arambagh Book House.p.28.

The process of becoming socially older can involve the acquisition of new forms of power, influence and security; particularly in the context of family[88].As the social age progresses, the individual experiences a decrease in meaningful social interaction. In addition; the social development, marriages of children, avoidance of sexual activity, privileges and respect on the basis of one's age also serve as the basis of recognizing oneself as an ageing person[89]. Social ageing can be controlled by transmitting positive images of ageing to the younger generation and that is through the process of socialization[90].

d. **Cultural Ageing:** From the socio-cultural perspective, an individual is termed aged when he distances himself from those roles and statuses which he was performing as an adult. He becomes disengaged from his normal adult roles .Social and cultural ageing are inter-related concepts, but they differ from one another on the basis of their emphasis. Social ageing emphasizes the changes in behavioural pattern and the role and status of individuals in the family. On the other hand, the cultural ageing gives importance to the role of an individual during his life span[91]. It is defined as the cultural progression of an individual through different stages of life[92]. This view of ageing advocates the gradual withdrawal from the social roles and duties of the society. It is often thought of as an extension of life during which paid employment or self-engagement is shortened and leads to total retirement[93].

e. **Chronological Ageing:** Chronological ageing is the most widely used and straightforward dimension of ageing. It continues from birth until death. People age chronologically as they clock up their birthdays[94].Chronologically, 'old age' is divided into two or three categories as young-old (between 60 to 69 years) and

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88 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. p. 43.

89 Lymbery, M. (2005).*Social work with older people: context, policy and practice.* New Delhi: Sage Publications. p.23.

90 Mishra, G. (1997). *Ageing: The people's concern.* In Husain, M.G. (Ed.).Changing Indian society and status of aged. New Delhi: Manak Publications, p.139.

91 Tondon, S. (2006).*Senior citizens: perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.7.

92 Khan, M.Z. et. al. (1997).*A study of anxiety and pessimism-optimism among the elderly in Delhi.* In Husain,M.G. (Ed.). Changing Indian Society and Status of Aged. New Delhi: Manak Publications p.83.

93 Tondon, S. (2006).*Senior citizens: perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.7.

94 Mullan, Phil. (2002).*The Imaginary time Bomb: why an aging population is not a social problem.* London: Taurus Publishers. p.15.

old-old (70 yrs and above)[95] or young-old, old-old and oldest-old. The young-old (60-69 yrs) are the people which are mobile and experience little functional limitation. The old-old (70-79yrs) are people with some disabilities that lead to an increasing restriction of the function and can take care of themselves. The oldest-old (80 and above) are the frail group whose ever increasing disability quickly leads to total dependency and hence they need total support[96].

Chronologically, old age is different in different countries. In Korea, old age begins at age 45 years and over; in Japan and Australia it is the age period between 60-65 years[97], whereas in India, retirement age from regular job, either public or private, has been administratively accepted as a symbol of old age[98].Generally, age sixty is recognized as the starting point of old age in India (Census of India, 2001)[99]. Thus the chronological criteria for classifying an individual as 'aged' or 'elderly' is the operational means employed for administrative purposes-pensions, insurance and the like. It is basically transition from salaried work to retirement[100].

Chronological Age is not the best marker of old age:

Gerontologists and specialists in geriatrics have generally expressed reservations about fixing the onset of old age on purely chronological basis. They cite following reasons for this:

First is the ambiguity of the variable. Chronological age actually is an intrinsically ambiguous variable. There are no definite biological, psychological and sociological parameters which individually or collectively can demarcate the particular chronological age uniformly[101].

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95 Chattopadhyaya, K. (2006). *The aged in suburban context: study in social gerontology.* Arambagh Book House. p.29.

96 Bagga, A. and Dayabati, D.S. (2006).*Ageing in Women.*New Delhi: Mittal Publications. p.4.

97 Op.cit

98 Khan, A. M. (2005).*Empowerment of elderly-qsource of healthy ageing.*In Prakash, I.J. (Ed.).Ageing in India: retrospect and prospects. CCR-IFCU.Project Report on Ageing and Development.p.142.

99 Census of India, 2001.(2001). *Report of the technical group on population projections (TGPP),* New Delhi: Registrar General of India.

100 Rajan, S. I. and Mishra, U.S. et al.(1994). *A Survey of elderly in India: A study for assistance in thedevelopment of comprehensive National policies on ageing and lifelong preparatory measures includingsocial security.* Bangkok: Centre for Development Studies. Trivandrum and Social Development Section of Economic and Social Commission for Asia and the Pacific. p.16.

101 Sauvain, C. and Henri L. et al.(2006). *Human clocks: The Bio-cultural meanings of age, population, family and society.* Germany: Europian Academic Publishers, Bern. Vol. 5. p.35.

Another prime limitation in making chronological age as a standard marker of ageing is its link with life expectancy. It varies with life expectancy. For instance, in India, when the average life expectancy was 27 years, the age of retirement under the government schemes was 55 but with the rise in life expectancy to 64.8 yrs(in 2001), the age of retirement has also raised to 60 years[102].

In addition, the extraordinary variations among individuals of the same chronological age further limit chronological age in becoming a standard marker. It was observed that while some people may be "old" at 50 years while other seems young and energetic even at their 70th or 80th birthday[103].

The challenge to chronological age also lies in its difficulty in application. It is not applicable to all societies, especially in rural and tribal societies. This is because most of rural and tribal people do not even know their birthday. They reckoned their age by an associating it with geo-climatic occurrences like eclipses, floods, earthquakes and with socio-cultural events like festivals, rituals and the like[104].

Hence, from above dimensions it can be concluded that the concept of 'old' or 'aged' is a relative term. No dimension for ageing is complete in itself. Ageing differs from species to species. It also varies with purpose, viewpoint, sex, residence, climate and the like. It varies between urban and rural individuals. It is even conceived differently by the old and non-old[105].Considerable variability and differences also exist among older adults. They don't age exactly alike, chronologically or otherwise.

Therefore, as a consequence of this variability, other ways of conceptualizing old age are needed. Some scholar posited the need of a definition of old age based on function rather than chronological age[106].'Functional age' is actually the capacity to behave in accordance with what is expected at any given age. Functional age may be determined by appearance and normal physical changes like stiffness of joints, diminished short-term memory, reduced skin elasticity etc. In functional term, a person becomes old

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102 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications, p.23.

103 Richard, A. S. (2006). *Ageing and the Life course.*In Binstock, R. H. and George, L. K. (Eds.). Handbook of ageing and the social sciences.6th Edn. Academic Press. p.8.

104 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies, p.38.

105 Ibid, p.37.

106 Ibid, p.40.

when he or she can no longer perform the major roles of adulthood[107].The notion of functional age would therefore be helpful in establishing more appropriate functions for social policies on one hand while keeping the dignity and worth of the individuals on other[108].

Whatever may be the dimension; ageing is an issue of serious concern. With more participation of aged in the society according to their special abilities and experiences; with greater vigor in the old along with the young; with quicker maturation of young and the less quicker ageing of old; and with political, human and economic rights being more evenly distributed across the age groups; the result is likely to be a society in which age categorizes and age restrictions will be relaxed and society may age happily.

Further to understand the ageing processes and needs; few important theories have been analyzed as under:

1.12: Theories of Ageing:

There exist many theories and approaches to understand the process of ageing. Different theories looked at the ageing phenomenon differently. Few considered aged as a social group while other recognized them as an individual observing personality changes. The analysis of these approaches is therefore required to get a better understanding of the research problem. The following are the major theories of ageing:

1. Disengagement Theory:

Disengagement was the first formal theory of ageing. It was proposed in 1961 by two prominent researchers of Chicago University named as Elaine Cumming and William Henry. Disengagement, according to them, is a natural process which the ageing person accepts and desires but the degree of disengagement differs from an academician to a skilled workman.

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107 Quadagno, J. (1999). *Aging and the life course: An introduction to social gerontology.* Tata Mc. GrawHill.p.8.

108 Sauvain, C. and Henri, L. et al. (2006).*Human clocks: The Bio-cultural meanings of age, population, family and society.* Germany: Europian Academic Publishers, Bern. Vol. 5.p.34.

This theory begins from the functionalist premise that society and the individual always seek to maintain themselves in equilibrium and avoid disruption. It interprets the loss of social role and relationship as a functional necessity[109].

Disengagement involves the separation of an individual from several of his or her regular social roles and activities. Disengagement theory argued that intrinsic and hence inevitable changes occurred in personality in late life which decreases activity of an individual; this personal withdrawal coincided with functional societal need and results in the separation of an individual from several of his or her regular social roles and activities[110].This readiness for disengagement occurs when the individual becomes aware of the shortness of life and the scarcity of time remaining to him, and if he perceives his life space as decreasing.

Hence, disengagement theory takes into account some of the facts of development in later years and was based on the basic assumption that, as a natural development, withdrawal from the physical and social environment occurs during old age. The basic criticism to this theory was the fact that it does not correspond to observations of some aged who are both extremely active and creative in old age or extremely distressed at being forced to withdraw from social contacts[111].

2. Activity Theory:

Activity theory was put as an alternative to disengagement theory. It was formalized by Robert Havighurst. Activity theory says that the more active an aged person is, the better his morale will be. Havighurst argued that the psychological and social needs of elderly were no different than those of the middle aged and that it was neither normal nor natural for older people to become isolated and withdrawn. When they do, it is often due to events beyond their control such as poor health or the loss of close relatives. The person who aged optimally managed to stay active and resist the shrinkage of his or her social world[112].

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109 Ara, S. (1994).*Old age among slum dwellers.* New Delhi: South Asian Publishers. p.12.

110 Banerjee, M. and Tyagi, D. (2001).*Role adjustment and the status of aged:A case study of Bengalipopulation of Meghalaya.* In Modi, I. (Ed.). Ageing and human development: Global perspectives.New Delhi: Rawat Publication. p.354.

111 Stone, R.I. (2006). *Emerging Issues in Long-Tderm Care.*In Binstock, R. H.and George, L.K. (Eds.). Handbook of ageing and the social sciences.6th edn.Academic Press.p.412.

112 Sugarman.B. L. (2005). *Life-Span Development: Frameworks, Accounts and Strategies*NewYork: Tylor and Francis Inc. pp. 28-30.

Activity theory assumes that a "successful old age", will be one, in which the individual actively engages in forms of behaviour which compensate for him or her lost roles. Present theory correlates the higher morale and life satisfaction with the social integration[113]. Activity theory purportedly emphasized social integration and involvement as the explanation of life satisfaction whereas the disengagement emphasized on withdrawal of affective attachment and withdrawal from conventional involvement in social roles. Both perspectives, however, predicted successful adaptation as the expected outcome[114].

3. Continuity theory:

Continuity theory represents a more formal elaboration of activity theory. It was first proposed by Robert Atchley in 1989 and was based on the concept of internal and external continuity. Internal continuity signifies a remembered inner structure, such as the persistence of ideas, temperament, affect, experiences, preferences, dispositions and skills etc., whereas, external continuity is connected to past role performance and can be observed in the continuity in skills, activities, environments, roles and relationships between middle and old age.

Continuity theory emphasized that personality plays a significant role in adjustment to ageing and that adult development is a continuous process. By the time people reach middle age, they have built a life structure that is linked to their past and becomes the base upon which they build their future.

Continuity of personality means that changes can be incorporated that still preserve the unique characteristics of an individual. Continuity of activities allows people to prevent, offset, or minimize the effects of ageing. Continuity of relationships preserves an individual's social support system. Thus continuity is considered as an adaptive strategy for successful ageing.

Continuity theory also defines normal ageing and distinguishes it from pathological ageing. Normal ageing was defined as a "usual, commonly encountered patterns of human ageing." It can be distinguished from pathological ageing by a lack of physical or mental disease or illness. People who age normally can successfully meet their

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113 Ara, S.(1994). *Old age among slum dwellers*. New Delhi: South Asian Publishers. p.12.

114 Settersten A. R. (2006).*Aging and the Life Course*.In Binstock, R.H. and George, L.K. (eds.). Handbook of ageing and the social sciences. 6th edition. Academic Press.p.15.

needs because they are poor or disabled. The theory has been criticized for pathological ageing by stating the fact that chronic illness does not preclude the ability to participate in society or in personally meaningful experiences[115]

4. Exchange theory:

Exchange theory is similar to psychological theories in explaining why some older people withdraw from social interaction. Its origin lies in micro-economic theory. A central premise of exchange theory is that resources are often unequal and that actors will continue to engage in exchanges only as long as the benefits are greater than the costs i.e. the social interaction between individuals is based on rational calculations and that people seek to maximize their rewards from these exchanges and minimize their costs.

Exchange theory assumes that human behavior and social interaction is an exchange of activity (tangible or intangible), particularly rewards and costs. Exchange theory explains that interaction between the old and the young decreases because older people have fewer resources to bring to the exchange like lower income, poorer health and less education. Their declining resources strain their possibilities for continued interaction with others. Thus social exchange; treated as the building block of a wide range of phenomena, such as, cooperation, competence, love, help, bargain and negotiation of inter-group conflicts; is reduced in old age[116].

Social exchange theory can be criticized at two levels of analysis. The first level pertains to the treatment of human behavior or social life as exchange; the second to the reduction of social interaction to economic transaction or a psychological process. At the first level, many exchange theorists pointed that every interaction is not an exchange. The second level of critique involves the relationship between economic and social exchange. Economic and behaviorist models tend to reduce social exchange to a set of market like exchanges of material objects driven by extrinsic motivations like game, even when it declaratively distinguishes between the two[117].

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115 Atchley, C .R. (1989).*A Continuity Theory of Normal Aging.* The Gerontologist Vol.29 No. 2, pp.183-190.

116 Jamuna, D. (2001). *Intergenerational Issues in Elder Care.*In Modi, I. (Ed.). Ageing and humandevelopment: Global perspectives.New Delhi: Rawat Publication. p.290.

117 Zafirovski, Milan. (2005). *Social Exchange Theory under Scrutiny: A Positive Critique of its Economic-Behaviorist Formulations.*In Electronic Journal of Sociology. pp. 15-29. Obtained From www.sociology.org/content/2005/tier2/SETheorry.pdf.

5. Age Stratification Theory:

This theory was outlined by Riley Johnson and Anne Fonnerin 1972.This theory viewed age as a fundamental social mechanism by which resources are allocated over the life course. It has its origin in status attainment research. The underlying assumption of this theory is the fact that all societies group people into social categories. These groupings provide people with social identities. It assumes that 'age' locates the individuals or groups of people in the social structure. Each age stratum is composed of people similar in life stage who tend to share capacities, abilities and motivations to age[118].Age is thus a basis for structured social 'inequality'. Age is perceived to be both a process and a structure. It further promoted the idea that societies organize the distributions of rewards and opportunities and develop sets of behavioral expectations based on the stratifying characteristics of their members, with chronological age as a central element in the system[119].

6. **Personality Theory:** This theory was proposed by Neugarten, Havighurst and Tobin in 1968. Theory denies the necessity for any sociologically oriented explanation of successful ageing. Instead, adjustment to old age is seen as the result of individual personality. This life cycle approach conceptualizes ageing as a developmental process, the outcome of which reflects the individual copying style. The exponents of the theory hold that people, as they grow older, seem to be neither at the mercy of the social environment nor at the mercy of some set of intrinsic processes. On the contrary, the individual continues to make his own impress upon the wide range of social and biological changes. He continues to exercise choice and to select the environment in accordance with his own long established needs. He ages according to a pattern that has a long history and that maintains itself with adaptation to the end of life. According to this theory, the integrated personalities are not necessarily integrated sociologically, in the sense of maintaining social roles and relationships. They are however, high in "life-satisfaction"[120].

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118 Dandekar, K.(1996). *The Elderly in India.* New Delhi: Sage Publications. p.10.

119 Harper, S.(2006). *Ageing Societies: Myths, Challenges and Opportunities.* New York: Oxford University Press. p.73.

120 Ara, S. (1994).*Old age among slum dwellers*. New Delhi: South Asian Publishers. p.12.

7. **Wear and Tear Theory:** This theory was suggested by Comfort (1956). It assumes that cell wears out with time or those waste products accumulate in cells can interfere their functions. It further suggests that ageing can be caused by damage that occurs in various body systems throughout their life. Such damages could be caused by 'wear and tear' and by the harmful substances that we breathe and eat, and natural processes within the body. It postulates that each stress to which an organism is subjected, take its toll and that the organism finally wears out. However, direct verification of data is lacking[121].

Thus from the analysis of above mentioned theories; it can be concluded that no theory is said to be complete in itself and hence a holistic perspective is required to understand the ageing phenomenon. The above theories further reflects that ageing phenomenon is generally defined by using two perspectives, namely, social structure and personal growth of an individual. Variations in social, cultural and individual patterns of growth were found to be a reason behind the different theories.

Along with theories, equally important aspect is to understand society's attitudes and stereotypes towards the aged generation. Gerontologists describe these stereotypes in terms of "ageism" which means that older people are in some way different from ourselves and our future selves and are not subject to the wants, needs and desires as the rest of the society[122].Few such attitudes are discussed as follows:

1.13: Attitudes and stereotypes of ageing:

The term 'Attitude' is "an individual's characteristic way of regarding an object, person or process". It involves evaluation: whether on likes/dislikes/approves/disapproves/seeks/avoids a particular object, person or process. Throughout their life span individuals develop following kind of attitudes:

- The attitude of individuals towards his age group.
- The attitude of members of his age group towards different other age groups[123].

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121 Bagga, A. and Dayabati, D. S. (2006).*Ageing in Women.* New Delhi: Mittal Publications. p.8.
122 Ibid, p.8.
123 G. L. Andres and H. et. al. (2001).*Ageism at School: Images and stereotypes of Ageing and the oldAge in Argentina'.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives.New Delhi: Rawat Publication. pp.160-177.

'Stereotyping', on the other hand, is a method of communicating particular social value on specific social groups and through social interaction with them by suggesting appropriate forms of behaviour. Besides, influencing our behaviour towards the target group, stereotypes also provide appropriate forms of behaviour to the group itself. Ageist stereotypes are transmitted in a variety of ways: through the family, in the work place, between groups of friends and through the media[124].

In general, the following stereotypes or myths associated with old age have been reported:

- Ageing and Senility: The myth of senile older adults.
- Ageing and Sexuality: The myth of the asexual older adults.
- Ageing and Health: The myth of sick older adults.
- Ageing and Social contact: The myth of isolated older adults.
- Ageing and Learning capacity: The myth of incapable and rigid older adults.
- Ageing and Gender: The myth of similar ageing for both the gender.
- Ageing and Homogeneity: The myth of alike older adults.

1) Ageing and Senility: The myth of senile older adult

It was believed that older persons "naturally" grow confused and childlike, become forgetful, and lose contact with reality. They become "senile". There mental abilities begin to decline from middle age onwards, especially the abilities of learning and remembering, and that cognitive impairment is an inevitable part of the ageing process.

Fact: The term "senility" is frequently used in discriminately applying it to anyone over 60 with a problem. It implies an assumption about elderly people that they are old, they are also mentally deficient. Indeed, in most cases, when the label senility is applied, no course of treatment is started. This is a myth.

In reality, most elderly people retain their normal mental abilities, including the ability to learn and remember. It is true that reaction time tends to slow down in old

124 Chadha, N.K. (2003). *Urban Ageing: Issues and Challenges*. In Dey, A.B. (Ed.). Ageing in India: Situational Anaalysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.96.

age and it may take somewhat longer to learn something. However, much of the difference between older and younger people can be explained by variables other than age including illness, motivation, learning styles, lack of practice, or amount of education. Significant learning and memory problems are due to illness and not to age per se[125].

Senility includes a range of symptoms including memory impairment, forgetfulness, decline in intellectual functioning and malnutrition, irreversible physical conditions such as heart attacks, diabetes, and excessive tranquilization etc. But in reality, some of these declines in mental functioning can be prevented or even reversed. According to an article in Tufts University review on ageing studies[126], 'vitamin deficiency is the cause for many of the symptoms of senility e.g. low folate levels in the elderly can cause forgetfulness, irritability and possibly depression'. Thus by simply adopting a life style rich in healthy diet, exercise, intellectual interests, friends, and a sense of purpose can help a lot in overcoming the myth of senile older adult.

1) Ageing and Sexuality: The myth of the asexual older adult

One of the most pervasive myths in our society is the belief that a decrease in sexual interest and a diminished capacity for sexual behaviour are an intrinsic part of the ageing process.

Fact: There is no particular age that signals an end to sexual feelings or abilities. The stereotype of the sexless older adults arises from the tendency to think of ageing as a disease instead of a normal process. Chronological age itself is not the critical factor in sexual activity or physical intimacy. While sexual activity does tend to decline with age, there are tremendous individual differences in this aspect of life. In part, these differences are determined by cultural norms, health or illness, and the availability of sexual or romantic partners. According to a study published in New England Journal of Medicine (2007) 'In the age group of 57 to 64 years; 73 percent had sex with a partner in one year'. In terms of sexual activity the main factor seemed to be not old age but availability of a partner. Thus older women were less likely to be sexually

125 Gastron, L. and Andres, H. et. al. (2001).*Ageism at School: Images and stereotypes of Ageing and the Old Age in Argentina.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p. 160-177.

126 www.ehow.com and www.globalhealingcentre.com

active because they often outlived their partner. In another study carried out at Duke University's Centre for Ageing and Human Development; 254 men and women between the age of sixty four and ninety four were surveyed about their sexual activity. Study found that majority of older individuals retained their interest in sexual behaviour and continued to participate in sexual activity[127].

1) Ageing and Health: The myth of sick older adult

One common prejudice is that older people are sick or disabled and that the majority of elderly people are not healthy enough to carry out their normal activities.

Fact:-It's true that as we age, our physiology changes. These changes can even lead to poor health. But old age doesn't have to mean feeling sick and tired. An important part of staying well into the older years is keeping one's immune system operating at its peak. Ageing is generally associated with lagging immunity and consequently more infections. There exists a correlation between how healthy a person expects him or herself to be and how healthy that person actually is. When older people accept the idea that to be old is to be disabled, he/she functions below their physical capacity. In a longitudinal study of aged, half the sample was found to relate their health worse than their doctors did. It is also observed that even with getting the best of care, not everyone remains healthy in old age. Another study based on 496 elderly teachers of Argentine revealed that most of them were healthy enough to engage in normal activities[128].

2) Ageing and Social contact: The myth of the isolated older adult.

The isolation of the elderly, diminished or nonexistent social interaction is another stereotype frequently attributed to older persons.

Fact: Older people do not live alone. They either live with their spouse or with their family and those who are living alone, are not necessarily lonely. Relationships may grow more intense in old age. In fact, gender differences in average life spans leave

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127 www.psichi.org

128 Gastron, L. and Andres, H. et. al. (2001).*Ageism at School: Images and stereotypes of Ageing and the old Age in Argentina.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p. 160-177.

many more women than men widowed. Widowed men are more likely to remarry than widowed women.

Cantor's study (1975) on the social interactions of city-dwelling seniors revealed dynamic relationship patterns. Over eighty percent sit and talk together with neighbours either in front of the building or in parks or open spaces. Almost two-third has a visiting relationship with neighbours and identified their neighbours as close friends and two-third reported monthly visits with their children. In a similar study of Sokolovsky and Cohen (1981) designed to measure social interactions among the urban elderly; results provided further proof to reject the isolation myth. Very few elderly were completely isolated. In fact, the majority of elderly had created complex social networks in their communities. The number of social networks ranged from 0 to 26, with an average of 7.5 social contacts per individual. 73 percent had formed social networks comprised of four or more individuals. Additionally, 44 percent of the social contacts made outside the hotels involved visit with relatives[129].

3) Ageing and Learning capacity: The myth of incapable and rigid older adult.

Older people can't learn anything new, they can barely remember what they used to know and refuse to adapt to new ways.

Fact: Ageing does not affect our ability to learn. The information processing literature does not support the idea that cognitive functioning declines with age. While we may experience some difficulty with short term memory as we get older, our long term memory generally remains sound. Older persons do, however, tend to solve problems differently than younger persons, preferring to "think things out" rather than relying on "trial and error." And while our reaction time increases with age and correlates with the complexity of a task, this increase is only measured in milliseconds[130].

Thus older people can and do learn new things, and they learn them well[131].However, the limits of learning and the pace of learning changes. Three key factors predict strong mental function in old age vis. regular physical activity, a strong social support

129 Ibid.
130 www.transgen erational.org
131 www.agemyths.com

system, and a belief in one's ability to handle things positively. Many laboratory studies, and of course programs such as elder hostel, have shown that older persons can learn new skills and recover proficiency on previously learned skills[132].

4) Ageing and Homogeneity: The myth of alike older adult.

It is generally believed that as we age, we lose our individual differences and become progressively alike.

Fact: Ageing does not affect us as a person; our personality remains fairly constant. Not only we retain our individual differences throughout our lives, these differences become even more pronounced as we get older. We generally become more like our youthful self; a talkative teenager, for example, becoming a talkative older person and a stubborn youngster carrying the trait of stubbornness into old age. In reality, an old person is a young person who has just lived longer[103].

The elderly do not form a homogeneous category. There are different groups among them, they should not lumped together purely on the basis of chronological age. Rather distinctions should be made with reference to income, residential pattern, age, sex, education, occupation, health, marital status, ethnicity needs etc. One can think of several groups among them. This is important because old age has different problems and implications for different groups. For example, effect of family cycle is more traumatic for women than men because of their deeper involvement in female roles in the domestic sphere. Widowhood has greater impact on women as compared to man. Further, the problems of persons who are required to retire from their service are different from those who are self-employed[133].

From the analysis of above theories, facts and stereotypes the following features of ageing have been identified:

1.14: Salient Features of Ageing:

- Ageing includes under its rubric both - the individual as well as population ageing.[134]

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132 www.healthline.com

133 Muttagi, P.K. (1997). *Ageing issues and old age care: A global perspective.* New Delhi: Classical Publishing Company. p.28.

134 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. p.28.

- Ageing is a universal phenomenon, even though its magnitude and manifestations are not the same everywhere.
- Ageing is far from being a uniform process. With a multitude of processes going on simultaneously within a bodily system, ageing is complicated and complex[135]
- Ageing is a contradictory process, where both growth and decline occurs.[136]
- Ageing has varied frame of references e.g. chronological, social, psychological, temporal and cultural[137].
- Ageing is a promiscuous term used in different contexts and can refer to diverse trends[138].

Hence, from all these features it can be easily inferred that ageing is a global phenomena and is inevitable. Every nation, irrespective of its pace of development, needs to inculcate ageing in its research agenda if they wants to celebrate ageing of its citizens. For becoming a truly welfare State; understanding of the implications of population ageing is required. Population ageing and its related problems need a long term planning along with continuous efforts. Keeping this broader objective in mind, the present study was conducted to diagnose the ageing problems of individuals living in cities. The more clear understanding of the research problem can better be understood from the following study rationale.

1.15: Rationale for the present study:

Population ageing is a global and universal phenomenon. Ageing of population is capturing the World's attention as one of the major policy challenge. The whole World is experiencing its consequences. The W.H.O has aptly Stated Population ageing as "one of the humanity's greatest triumphs'[139]. Actually, there is no escape

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135 Ibid, p. 28.

136 Allen, R.K. and Walker, J.A. (2006). *Ageing and Gender in families: A very Grand Opening.* InCalasanti T.M and Slevin K.F. (Eds.).Age Matters: Realigning Feminist Thinking. Rout ledge. Talyorand Francis group Publication. p.156.

137 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications. p.23.

138 Mullan, P. (2002).*The Imaginary time Bomb: why an aging population is not a social problem.* London: Taurus Publishers. p.13.

139 Awin.N. (2006).*The role of Government in Health and Ageing: experiences of Malaysia.* In Prakash, I.J. Ageing with Health and Dignity: Proceedings of the Asian Regional Conferences' 9th to11th Feb. Dept. Of Psychology. Bangalore University Press.p.2.

from ageing; rich or poor, man or woman, everyone has to face this natural phenomena. Even though many old people would like to separate them from the group of weaker sections of the society by stating that they are not old in any way, neither weak nor disabled. They are still able to do their work effectively. This may be true in exceptional cases but the hard fact remains that at some stage of life, one starts to face decline, some do it even earlier than thus defined; others at a much later rate, but decline does happen in normal ageing process. One cannot just wish away this decline, though delaying it is as far as possible, desirable and commendable[140].Hence to experience delayed and healthy ageing; understanding of the implications of population ageing is must.

The importance of ageing can not only be based on the growing number of persons considered as ageing people, nor must be taken as a fact due to increasing number of social actors of this kind. Social significance can't only depend on quantitative criteria. This phenomenon is grabbing the World's attention because it takes the Nation more and more towards planning. Further, it helps senior citizens to adapt themselves to the changing environment and face vulnerabilities.

Traditionally, Indian society assigned a place of honour and respect to the aged. All norms, religions, social values, and social and economic organizations of society give emphasis on the better quality of life of the elderly[141].But today the scenario has changed. Society is undergoing change as an impact of modernization, urbanization and industrialization. These forces put forth many social and demographic transitions. One such transition is the increase in the population of elder generation and decrease in the population of younger generation. This situation may create an imbalance in the society as it demands more caregivers; which is practically not possible due to the decline in the population of younger generation.

The care giving problem further became critical with the participation of women in labour market. Traditionally, woman was considered as the primary caregiver. But with rising responsibilities and shortage of time, women are not in a condition to

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140 Chowdhary, B. K. et. al. (2001), *Personality characteristics of working and retired aged people.* In Modi, I. (ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication,p.347.

141 Husain, M.G and Alam, R. (1997).*Psycho-Social Problems of Ageing: Indian Perspectives*. In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p.100.

spend enough time in care giving of their parents. Further, factors like breaking up of joint family system, selfish attitude of children, financial dependency of aged, deterioration of physical and mental health are all worsening the situation of aged in India. At this phase of life, most of the aged are unable to carry out their work and needs care giving. But formal care giving to every individual is not possible. This is due to some financial constraints.

Hence, in a situation like this few important issues may raise as what should be done to provide care and support to the aged? Why we discriminate ageing issues in India, yet so prevalent? Why elder generation is considered as "forgotten generation" though we have been reminded of their presence even in our own home? Why the elderly have barely captured the attention of young scholars in India. Is it because the elderly population of India constitutes one of the smallest and least understood segment of Indian population or we don't have enough resources to provide full care and social security to them. Whatever may be the explanation, what is important is the adding up of ageing issues to the recent debates of policy makers and planners.

In actual, elderly people are not a burden on the society and economy; they are in fact valuable resources and can contribute equally to the economic and social development of a country. This calls for policy makers and researchers to identify innovative roles for them. The problems of the elderly not just required a macro level planning but adopting strategies, practices and interventions at the grassroots level is equally essential. Need is to think for these dimensions from both micro and macro level.

At the micro level, need is to look into the ways in which people adopt their life to the important transitions occurring across their life course, whereas, at the macro-level, the challenges of growing ageing population based on the economy, education, health, family and welfare needs to be dealt with. Therefore, it becomes imperative to look into both of these aspects as it impacts on population structures and individual life-styles, which in turn, influence the quality of life of the elderly.

Although there have been made a number of attempts by the researchers, policy makers and demographers to look into the problems of ageing, there is still a need for carrying out more systematic and influential research. This is because the earlier studies were either influenced by the Western perspectives or they focused less on the interventions and coping practices part. Therefore, it becomes the prime responsibility

of present researchers to work in the direction of filling the gaps existing between theory and practice.

The present research is a minor step in this direction as it tries to locate not only the problems of the aged but will suggest the interventions and coping practices adopted by the senior citizens against their socio-economic and health problems. It further attempts to identify the ways of making individual ageing successful and healthy. Thus the present study has the following relevance:

1.16: Importance of the study:

The present study is assumed to be helpful in the following ways:

- Primarily, the study will help the individuals aged sixty and over in gaining access to their present situation and problems. It makes them realize that whatever they are facing is not just an individual issue rather a mass problem.
- It will help the organizations (both private and public) working on the ageing issues, in understanding the nature of problems experienced by the elderly belonging to small cities and thereby developing interventions accordingly.
- In academics, the resultant work can be helpful in filling the gap between theory and practice. It can further enlighten the academicians with the issues that need special concern from the side of planners and policy makers.
- It is further believed that the findings will help in identifying the effective coping practices against various socio-economic problems of senior citizens, which if properly followed, may lead to healthy and successful ageing.
- The investigation also proposes to identify those interventions which enable academicians, Social Workers, policy makers and planners to take necessary steps against the socio-economic problems of the senior citizens.

1.17: Review of relevant literature:

Social, cultural, geographical and financial imbalances between developed and developing nations gives an insight to the developing nations that they are different from the later in many aspects. The strategies and approaches adopted by developed

nations may or may not give significant results to the developing nations. Hence, they are bound to design their own strategies and interventions depending upon their own resources and funds. The present chapter is designed to find out all those approaches, guidelines and frame of references in terms of literature review and that too in accordance with the research problem.

Keeping this in view, the researcher made an effort to collect as much literature as possible on the present problem. An attempt was also made to develop a link between the previous and present day studies and then explain the nature and purpose of the present work. A bulk of literature was being reviewed with a hope that some effective guidelines may come out and which help the researcher in better understanding of the research problem. For simplification, the depth of literature being reviewed may be classified into the following broad categories:

- Studies in which attempt has been made to find out the origin, growth and development of ageing research in India.
- Studies highlighting the socio-economic problems of the aged and their causative factors.
- Studies reporting coping practices and interventions meant for the elderly in dealing with their socio-economic and health problems.

(SECTION A)

Ageing is a global phenomenon. It was also proved to be inevitable. Today every nation, irrespective of being developed or developing, recognized its concern. But still the pace of development of ageing research was a matter of consideration. It was only recently that the ageing research has gained acceptance from the World's known Gerontologists, Sociologists, Geriatricians and Social Workers. In India, the situation is even worst.

According to **A. P. Bali**[142], in pre-independence era, only a handful of researches on ageing had been carried out in India with a special focus on the problems and processes of ageing. These studies had been carried out by Psychologists,

142 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. p.52.

Anthropologists, Biologists, Sociologists and Social Workers. On analyzing the significance of these studies in the Indian context; negligible results have been found. This was because of the Western influence on Indian researches. Ageing at that time was considered as a problem of West and thus a handful of studies were undertaken by the scholars on the issues related to ageing in India.

Ishwar Modi[143]in his study reported the recognition of Gerontology as an academic discipline as the important landmark in the field of ageing research. He further highlighted that in 1960s, many associations were established to give recognition to the field of gerontology. Indian Gerontological Association established in 1968 at Jaipur was one such initiative. This association is totally devoted to the research and well-being of senior citizens. Since 1969, the association is publishing a quarterly journal entitled "The Indian Journal of Gerontology" with a sole focus on the issues and challenges of ageing. Thus with these minor initiatives, the field of Gerontology was accepted as an important area of research for aged.

In the meantime, when Gerontolngy was developing as an academic discipline, 'Geriatrics'- another specialty had also came into existence. According to **A. Venkoba Rao**[144]; 'Geriatrics, as a specialty was developed in Britain due to the increasing proportion of older people as this increase in ageing population required more specialized physicians'. Thus Geriatrics was developed as a collaborative specialty to include medical and surgical specialties along with psychiatry and community medicine.

In India, the concept was first prioritized by Indian Council of Medical Research (ICMR). ICMR not only recommended, but also established the first Gerontological Institute in India. Further with the establishment of The Geriatric Society of India in 1978, another field of ageing research had gained acceptance and marked the beginning of the scientific research on ageing.

But **A. Bose and M. Shankardas**[145]hold a different view. According to them, the systematized research on the elderly and the focus of government's concern for the

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143 Atal, Y. (2001). *The United Nation and Ageing*.In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.7.

144 Rao, V. A. (2003). *Care of older people: evolution and future prospects*. In Dey, A.B. (Ed.). Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare.Rakmo Press Private Limited. New Delhi. p.43.

145 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal; Statistics Speak*. New Delhi: B.R Publishing Corporation. p.7.

elderly as a priority began with India's participation in the W.H.O's first World Assembly on Ageing, held at Vienna in 1982; where India along with other nations adopted the United Nations International Plan of Action on Ageing. It was before the 'Vienna Plan', both the terms -Gerontology and Geriatrics- have not been truly accepted. He reported that even the twelve volumes of Oxford dictionary of 1933, did not have any mention of either 'Geriatrics' or 'Gerontology' in it.

Following similar line, **P.V. Ramamurti**[146]also reported 'Vienna Declaration of 1982' as a revolutionary measure in the field of ageing research. This was due to the establishment of the Association of Gerontology in India in the same year as that of the Declaration. The Association's primary objective was to bring all the gerontologists of India together. It was also committed to evolving a comprehensive understanding of the ageing process; to aid judicious planning for the care of the elderly; and to promote coordinated action in the implementation of the action programmes.

Arun P. Bali[147] also highlighted few initiatives which play a significant role in the process of generating interest among the scholars towards the old age issues. One such initiative was the establishment of the Centre for Gerontological Studies at Tiruvananthapuram, under the chairmanship of Prof. P. K. B. Nayar. The Centre has been engaged in promoting studies and research on ageing and conscientising academic, administrative and professional elites on the urgency to develop early and adequate measures to cope with the problems of ageing. It strives to achieve this through study reports, seminars, workshops and conferences.

In 1983, the Centre for Research on Ageing was established under the aegis of Department of Psychology at Sri Venkateswara University, Tirupati. It also came up with more than 200 publications under the abled guidance of Prof. P.V. Ramamurti. In 1988, Calcutta Metropolitan Institute of Gerontology was established by Dr. Indrani Chakravarty. The Institute is responsible for providing services to the aged and is engaged in action-oriented research for improving the quality of life of the aged. In 1990, the Institute came up with a bold initiative of publishing a quarterly

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146 Ramamurti, P.V. (2003). *Perspectives and Research on Ageing in India.* In Phoebe S. L. (Eds.). Anaging in India: perspectives, prospects and policies. New York: Haworth press. p.34.

147 Bali, P. A. (2001). *Care of the elderly in India: Changing configuration.* Shimla: Indian Institute of Advanced Studies. p. 59.

journal named "Ageing and Society: The Indian Journal of Gerontology". Since then the journal is reflecting the problems and issues of the elderly population.

He further reported the importance of private sector in dealing with the problems of aged. Help age India and Age well Foundation were few such organizations which are really doing well for the cause of the aged. These NGOs are also funding many grass-root level organizations. Help age India is also publishing a quarterly journal entitled as 'The Research and Development Journal', focusing on the issues affecting the quality of life of the elderly.

P.V. Ramamurti[148] also highlighted slower growth rate in the field of ageing research .The study reported that the first educational programme i.e. the Post-Graduation course on ageing was first initiated in 1978 at Sri Venkateswara University. Since then the students were getting an opportunity to do M.Phil and Ph.D on issues related to ageing. These studies, in turn, attracted the premier agencies to undertake research on ageing and provide funds. For example, The Indian Council for Social Science Research, The Indian Planning Commission, The University Grants Commission, The Planning Commission, The Department of Social Welfare, G.O.I, and the Ministry of Social Justice and Empowerment had provided (and are likely to provide) funds for the welfare of aged. The ICMR even constituted a separate task force on ageing and developed a research agenda.

In addition, International agencies like UNESCO, WHO and ESCAP have promoted research in the area of ageing and award fellowships and grants. He also reported one thousand research articles published in refereed journals and more than fifty research projects in the field of ageing. He further observed an increase in the publication of magazines and newsletters for senior citizens. Besides, the development of NCOP and celebration of International Year for the Elderly in 1999 were identified as few other initiatives which may bring speed into the field of ageing research. Thus ageing research in India has gained acceptance only recently. It is recently that the different voluntary organizations, academic institutions and government agencies have shown their interest in the field of ageing.

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148 Ramamurti, P.V. (2003). *Perspectives and Research on Ageing in India.* In Phoebe, S. L, (Eds.).An aging in India: perspectives, prospects and Policies. New York: Haworth press. p.34.

I. J. Prakash[149] reported that one of the pioneering steps in ageing research was made recently in terms of the introduction of gerontology and geriatrics into the main stream of education. Diplomas and Certificate Courses in gerontology were initiated. He listed those Universities in India where Gerontology has been added as one of the subjects in the curricula including Longevity centre of Pune, National Institute of Social Defence in Delhi, S.V. University at Tirupathi and Heritage Hospitals at Hyderahad. Moreover, TISS, NCERT and IGNOU were reported as the other players in the field of ageing research. In addition, UGC has prepared separate curriculum for Geropsychology, whereas the AIIMS used to conduct continuing medical education programmes in Gerontology and Geriatrics. These initiatives along with variations in approach made ageing an area of research with interdisciplinary amalgams.

A. Bose and M. Shankardas[150] noted these amalgams as applied gerontology, critical gerontology, educational gerontology, dialectical and experimental gerontology, hermeneutic and qualitative gerontology, social and anthropological gerontology, and financial gerontology respectively. It was further noted that each field was having its own social significance and each one is imposing narrow boundaries on the subject in a different way. For example, **M.S. Randhwa**[151]called social gerontology as a contingent process relating to the social and demographic structure of human groups, the personal status, dynamic component of stratification in terms of generational membership, and questions about exploitation, victimization and stigmatization. It therefore involves both the individual as well as societal aspects of ageing.

A. P. Bali[152], on the other hand, considered educational gerontology as the most appropriate field for embracing education to older adults, public education about ageing, and the education of professionals and Para-professionals. This was found to be the best practice during the problems of instruction and learning.

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149 Prakash, I.J. (2001). *On being old age female: some issues in QOL of elderly women in India.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication,pp.333-341.

150 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal: Statistics Speak.* New Delhi: B.R Publishing Corporation. p.18.

151 Randhwa, S. M. (1991). *The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.3.

152 Bali, P.A. (2001). *Care of the Elderly in India: Changing Configuraton.* Shimla: Indian Institute of Advanced Studies. p.58.

Miriam Bernard[153], on the other hand, reported critical gerontology as the most promising practice in the changing conditions of both men and women. Thus each field of gerontology is found to be significant in its own way.

A. Bose and M. K. Shankardas[154]reported that these fields are not only significant but also shares a common basic goal i.e. to learn more about the ageing research- not for the purpose of extending life span but for the purpose of possibly minimizing the handicaps and disabilities of old age. This objective clearly reveals that scholars are now showing more concern towards the needs of aged and hence working in the direction of promoting the ageing research. In contrast **N.K. Chadha and R. Sinha**[155]commented that ageing was the most neglected area in the developmental research. They argued that although one spend one quarter of his/her lives in growing up and three- quarter in growing old but still the Psychologists, Sociologists and others have devoted their efforts in studying childhood and adolescence, rather than old age.

Similarly, **M.S. Randhwa**[156]opined that indifference to ageing research exists in India. He further reported the reason behind this indifference and negligence. According to him, the indifference exists because of the fact that the maximum studies on ageing had been carried out in developed nations only leading to the Western impact on Indian researches. He further acknowledged that the growth and development of ageing research was quite recent in India. It is only in the last few years that ageing has attracted the attention of social scientists, social reformers and the State and Central governments. Similar view was hold by **Shabeen Ara**[157] and **Yogesh Atal**[158] in their respective studies. Thus from above studies, it was clearly reflected that the ageing research in India is still in its phase of infancy.

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153 Bernard, M. , Chambers, P. and Granville, G. (2000). *Women ageing: changing identities, challenging myth.* In Bernard, M. and Phillips, J. et al. (Eds.). Women ageing: changing identities, challenging myths. London: Routledge Publication. p.3.

154 Bose, A. and Kapur.M. (2004).*Growing old in India: Voices Reveal; Statistics Speak.* New Delhi; B.R Publishing Corporation.p.18.

155 Chadha, N.K. and Sinha, R. (1997).*Problem of Elderly in Indian Family.* In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p.150.

156 Randhwa, S. M. (1991)*The Rural and Urban Aged.* New Delhi; A.H. Marwah Publisher.p.3.

157 Shabeen, A. (1994). *Old age among Slum Dwellers.* New Delhi: South Asian Publishers. p.13.

158 Atal, Y. (2001).*The United Nation and Ageing.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. pp.1-9.

Similarly, **M. Easwaramoorthy et.al**[159] confirmed that the Indian research efforts on ageing would lag behind the developed nations. They further highlighted the fact that the attempts made in the field of ageing research in India are not scientific; and if scientific; are not adequate. This they found as a challenge for systematic inquiry because any systematic inquiry needs a scientific approach for its survival.

A.P. Bali[160] characterized conspicuous absence of both longitudinal and cross-sectional studies of ageing in India. He also marked an absence of comparative research along with the issues of financial, emotional and health cost of home care to care givers and care recipients. He founded that a number of factors being working behind this irrational attitude of scholars including: the paucity of funding arrangements on a long term basis, lack of professional training and orientation, and absence of institutionalized framework that support and encourages such research endeavours.

Shabeen Ara[161] in her study also assessed the reason behind the ignorance of aged and highlighted the lower representation of aged in the total population as the basic reason behind this indifferent attitude. She further informed that from 1960, with gradual rise in the number of aged persons, the area of ageing would have received some concern from the scholars across the nation.

Similarly, **Irudaya Rajan**[162] opined that the ageing research had been given representation on developmental agendas only recently. The reason he cited was the increasing numbers and deteriorating conditions of aged. The increase in the number of aged is an impact of demographic transition whereas the deteriorating condition is a result of the fast eroding traditional system in the wake of rapid modernization, migration and urbanization.

In this regard, **Gordan. F. Strieb**[163]also noticed that young scholars either avoid or tend to show lesser interest in working for the issues related to aged. The reasons they

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159 M. Easwaramoorthy and Chadha, N. K. *Quality of life of the aged in Tamil Naidu.*paper 93-114.

160 Bali, A.P. (2006). *Gerontological research and action: A stock tale'.* In Prakash, I.J. Ageing with Health and Dignity: Proceedings of the Asian Regional Conferences 9th to 11th Feb. Deptt. of Psychology. Bangalore University Press.p.28.

161 Shabeen, A. (1994). *Old age among Slum Dwellers.* New Delhi: South Asian Publishers. p.13.

162 Rajan, I.S. (2003).*Demography of Ageing.*In Dey, A.B. (Ed.).*Ageing in India: Situational Analysis and Planning for the future.* Ministry of Health and Family Welfare. Rakmo Press Private Limited. NewDelhi. p.3.

163 Streib, F.G. (1970). *Old age and the family: facts and forecasts.* In Shanas, E. (Ed.). Aging in Contemporary Society. London: Sage Publication. p.25.

cited were two folded- first is the prevalence of youth oriented culture because of which old age is not considered as a captivating topic to study. Second is the fact that old age issues are not as popular and interesting as the issues related to other age groups because old age is generally concerned with decline and death and thus the young scholars tend to avoid ageing issues. In relation to above findings, **Yogesh Atal**[164]also highlighted few more factors responsible for the lower representation of aged in the academic research. These include shorter longevity as compared to the developed nations and the appearance of the problem. He found a wide gap in between the nature of problems between the developed and developing nations. In developed nations; the problems related to ageing had already been practiced and the strategies were already designed to incorporate 'curative measures', whereas, in India the problem is still in its phase of inception. It was generally believed that the problems of the aged are not so grave in India as compared to the developed nations. This was due to the strong family bonding. Many issues like financial burden on government to provide social security; burden of paying pensions to the retirees for a longer duration; burden of giving proper health care etc. had put forward the ageing problems in focus. Hence he suggested for developing a separate model of ageing research in India reflecting more on the preventive aspects.

Snehlata Tondon[165]opined that the current research on ageing was affected by the problem of non-involvement of the aged in the formulation of research questions, conceptualization of ageing problems and the evaluation of action strategies. She further argued that the aged know their needs best and they are the best judges to identify their welfare services. Thus participation of aged serves as an effective tool in determining the future direction of ageing research. The study also suggested that the current trends in the field of ageing research have been directed towards the understanding of the changes that have been brought about by the process of ageing in their family and related socio-economic aspects. Moreover, the status of aged, availability of medical facilities, changes in family life, retirement from work, source of income, leisure time activities, areas of deprivation, need for institutionalization,

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164 Atal, Y. (2001).*The United Nations and Ageing.*In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.3.

165 Tondon, S. (2006).*Senior citizens: perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.19.

and utilization of welfare services have also been accorded an important status in the field of ageing research.

In addition to identifying the future areas; studies were also needed to determine the ways through which the interest of young scholars towards the ageing research will be generated. Keeping this in mind, **Dr. A.Venkoba Rao**[166] in his study reported that the social factors are playing significant role in generating interest among the scholars towards the ageing research as compared to the demographic ones. Social factors include: social norms, cultural obligations and religious cults. He further argued that the care of aged was a duty in our religious cults. Upanishads speaks of active and joyful ageing. Ayurveda considered old age as a natural disease which was irremediable. Thus going back to Vedas and practicing our own culture were suggested as two important strategies against the generation of interest amongst the scholars in the issues of ageing.

Arun P. Bali[167]outlined the various phases of ageing research along with their areas of concern. He pointed that before nineteenth century, the ageing was considered as a social problem; reflecting the time-related changes in the individual organisms and personality and the losses that were expected to characterize later life. In 1920s, the focus was shifted from purely medical aspects of ageing to that of the broader aspects, including the phenomenon of social changes. During 1950s, Social gerontology had became the focus of concern and by 1970s, many areas like health, psychological status, socio-economic status, the welfare schemes, role of government concerning the aged, role of family in care giving and informal care were all added in the ageing research. Since 1990, the field of ageing research is covering a wide spectrum of issues, namely, old age policies, structure of work and family, widowhood, gender roles, feminization of elderly, future patterns of retirement, HIV/AIDS, Quality of Life, bio-ethics of ageing, loss and coping with transition, changing technology, workplace and education, role of social networks, and support systems in the care of the elderly etc.

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166 Rao, Venkoba .A. (2003).*Care of older people: evolution and future prospects*. In Dey, A.B. (Ed.).Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare. Rakmo Press Private Limited. New Delhi. p.43.

167 Bali, A.P.,(2006). 'Gerontological research and action: A stock Tale'. In Prakash, I.J. 'Ageing with Health and Dignity: Proceedings of the Asian Regional Conferences' 9th to 11th Feb, Dept. of Psychology, Bangalore University Press, pp.13-24.

P.V. Ramamurti[168]also outlines the summary of the Indian research efforts. He found that the ageing research is performing three basic functions. First, it provides normative data on the overall status and needs of the elderly. Second, it helps in understanding the basic ingredients of a good quality of life for the elderly and finally, it directs the formulation, execution and evaluation of appropriate interventions of improving the quality of life of the elderly.

Recently, many studies acknowledged the need of focusing on the new paradigm of ageing research i.e. the 'life-course' perspective. According to **A. Bose and Malakapur**[169], 'life-course' perspective considers the present in the context of past and the significance of social structure in shaping individual experiences. Life course perspective analyzed the patterns of meaning, context and change in older people's lives and brings in the strength of qualitative apprnaches.

Richard A. Settersten[170] holds a view that the life-course perspective was introduced in social gerontology to expand the word 'social' in it. The perspective not only pursue immediate answers to the current problems by focusing on individuals who are already old, but will also focus on predicting the future needs of those who are not yet old. Therefore, this perspective will not only foster more effective social planning and policy making but will bring important opportunities and obligations to build greater compassion and concern for senior citizens.

In another study, **Valerie Moller**[171] acknowledged 'partnership' as the new and dominant research paradigm of ageing. Participative approach was preferred over other approaches because in participation, the older people themselves control and own their services. They themselves carried out the social investigation to gain better knowledge and understanding of their situation. Participative research can also be used as a tool for empowering the older people .It is both- the research products and the research processes- that can empower older people. The findings of participative research would help in shaping public opinion, influence policy and contribute in

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168 Ramamurti, P.V., (2003). 'Perspectives and Research on Ageing in India'. In Phoebe S. Liebig (eds.),*an aging in India: perspectives, prospects and Policies*. Haworth press, New York, p.33.

169 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal; Statistics Speak*. New Delhi: B.R. Publishing Corporation. p.18.

170 Richard, A. S. (2006). *Ageing and the Life course*. In Binstock, R.H. and George,K.L. (Eds.).Handbook of ageing and the social sciences.6th edn.Academic Press.p.14.

171 Moller, V. Research as a tool for empowerment. In Thursz, D. et al. (Eds.). Empowering older people: An international approach. Indian Federation on Ageing.p.201.

better understanding of elderly groups that are excluded from the mainstream. Hence this new paradigm, if adopted, seems beneficial for the welfare of senior citizens.

Richard A. Settersen[172] while exploring the scope of ageing research found that the scope do exist and will continue to exist in future. This is because of the need to reveal the nature, sources and variability among the aged for developing social programmes and policies; the explosive growth in the number and proportion of older people in the population prompting major social changes; and the fact that retirement and healthcare policies are significant issues for a nation.

Easwaramoorthy et.al[173] in his study highlighted few benefits of conducting ageing research. For instance, the findings of the ageing research may guide the government and welfare agencies in designing policy and programmes for the aged; it helps the medical professionals and mental health professionals in better understanding of the problems of elderly; and finally, it helps the Social Workers and other professionals in designing intervention packages for the aged. Thus in no way it is going to produce a loss to the researcher.

Hence from above literature, it could be inferred that ageing is a multi-dimensional and multi-disciplinary area of inquiry. Earlier scholars ignored the need of conducting more rational and scientific researches on ageing because of the lower representation of aged in the total population. In addition, a kind of social stigma was attached to the aged. But slowly and gradually the scholars are also acknowledging the need of carrying out more qualitative and need based research. Presently, we have literature covering a wide spectrum of issues associated with the life of aged. Thus ageing is widely accepted as an important area of research among the social scientists, Academicians, Social Workers, Medical professionals, Anthropologists and Psychologists. Thus in the next section of literature review the various issues of ageing have been covered .

(SECTION B)

This section of literature review deals with the problems of elderly people along with their causative factors. In general, ageing is considered as a major social problem of

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172 Op.cit

173 Chaddha, N.K. (1997). Ageing and the aged: Challenges before Indian Gerontology. New Delhi: Friends Publication. p. 94.

almost all societies. However, the nature and extent of ageing problems may vary from one society to another. For instance, **M.S. Randhwa**[174] compared the problems of rural elderly with that of their urban counterparts in Punjab. The findings revealed a significant difference in social, health, psychological and economic aspects. Substantial difference was also observed in between the individual and group psychology. The difference was found due to the differences in the social institutions, cultural milieu, customs and traditions, and religious and community controls.

Dr. R. Kasthoori[175]conducted an empirical study based on 300 elderly people at Trivandrum to analyze the major problems of the elderly. The findings reveal social, economic and health problems as the major problems of the elderly. Social problem, according to him, is not about having a large number of aged persons rather it refers to the lag in adapting social institutions to the need of older people without disrupting the machinery of whole society. Social problem affects the aged from both sides; from one side it leads to the problems associated with poverty, illness and isolation, whereas, the other side reflects the problems of adjustment in the family and society to the new patterns of life. The economic problems of elderly were found to be associated with poor financial status. Income was reported as an important variable in the life of senior citizens. The old age problems are even reported as the problem of poor and lonely people. The study also reported of having a mutual relationship in between the old age and disease. The presence of a number of diseases, the chronic nature of the diseases, the disinterest of the doctors to treat the old etc. make the health conditions of the aged vulnerable. The commonly found diseases in old age were reported as rheumatism, arthritis, Blood Pressure, heart diseases and general disability. Old age was also found to be associated with declining physical and mental health making it difficult to adjust with the new ways of life.

In another study of similar nature, **D. Paul Chowdhary**[176] classified the problems of elderly into the following broad categories: economic, physical, psychological, psycho-social and environmental. The economic problems were including the income deficiency and loss of employment or work, whereas the physical problems include

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174 Randhwa, M.S. (1991).*The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.3.

175 Kasthoori, R. (1996). *The problems of the aged: A sociological study.* New Delhi: Uppal Publications. pp.11-13

176 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications, p.106.

disabilities and chronic illnesses like weak eye sight, diminishing hearing capacity coupled with lack of nursing and medical facilities, physical abuse and lack of shelter etc. Similarly, the physiological problems were reported as nutritional deficiency, falling health and housing problems followed by the psycho-social and environmental problems including the feeling of neglect, loss of importance in the family, feeling of loneliness and unwantedness, inadequacy of skills, education and expertise etc.

Pushpa Rani[177] conducted her study on Institutional care of the aged living in the old age homes of A.P. The sample of 130 elderly was taken to identify the problems of people living in old age homes. The problems of the elderly were than grouped into economic, medical and socio-psychological categories. The major problems thus identified amongst the 'young-old' (b/w 60 to 70 yrs) age group are the loss of employment, economic dependence, loss of social status and the problem of adjustment due to sudden role transitions, whereas the 'old-old' age group was affected more by the problem of poor health as 79 out of 130 respondents were bed-ridden and were totally dependent on others for carrying out their activities of daily living.

S. Kaur and M. Kaur[178] in their study from Kharar village of Haryana based on the sample of 60 males elderly explored that the problems of aged ranges from ensured and sufficient income to that of sound health, creative use of free time, social security, inadequate love, recognition, dignity and self-respect. Mental problems are also found to be more acute in old age as compared to the physical ones.

In another study, based on the urban slums of Baroda to identify the socio-economic problems of elderly; **T.G.Vaswani**[179] explored physical neglect as the most common problem experienced by majority of senior citizens followed by financial hardship, reduced interaction with family and friends, lack of participation in decision making and feeling of disrespect. The respondents often complained of their family for giving low priority to their health status as one-fourth of the elderly reported that they had not been taken to the hospitals even after making complaint.

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177 Rani, P.M. (2001).*Institutional care of the aged.*In Modi. I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.313.

178 Kaur, S. and Kaur, M. (1987).*Psychological Problems of the Aged.* In Dak T.M and Sharma M.L. (Ed.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.76.

179 Vaswani, T.G. (2001). *Family care of the elderly: Abuse, Neglect and abandonment.* Indian Journal of Social work. Vol. 60.July Issue.pp.492-504.

Shubha Soneja[180] in her country report for W.H.O. reflects the problems of female elderly in three socio-economic strata. The findings revealed a significant difference in the nature of problems experienced by females belonging to each stratum. For instance, in lower income group, health problem acquired the top most position followed by the economic hardship, lack of care, maltreatment and lack of space within the existing housing structure. The problem was also observed in the functioning of their roles. In middle-income group; the women prioritized economic problems as the most severe problem followed by lack of emotional support from family and friends, health problems, and the problem of inadequate housing. The third group comprised of elderly women belonging to the higher socio-economic strata complained of having mental health problems as their priority. They often reported lack of work, lack of opportunities to spend their leisure time, lack of emotional support, lack of caring attitude by the family, economic exploitation and general feeling of loneliness as their major issues. Among the health problems they stressed more on immobility and physical disabilities. Hence, a significant difference is noticed in the nature of problems experienced by the respondents belonging to three income groups. Therefore, financial status must play an effective role in identifying the nature of problems for the elderly.

In another study, **James Joseph**[181] made a comparison between the problems of aged living in institutions to that of non-institutionalized elderly. The findings revealed that the aged living in their own homes were facing more the problem of adjustment whereas, they experienced lesser financial and religious problems as compared to their institutionalized counterparts. On the other hand, the institutionalized elderly reported interpersonal problems as the most common problem followed by the problem of uncontrollable anger, lack of friends, lack of opportunity for social contacts and lack of consideration by family as their major areas of stress.

In a similar nature of study, **R. Bakshi et.al**[182] compared the nature of psychological problems of aged living with families to that of aged living in old age homes

180 Soneja, S. *Elder Abuse in India; Country Report for World Health Organization.* New Delhi: HelpAge India. p.4.

181 Joseph, J. (1991). *Aged in India: Problems and Personality.* Allahabad: Chugh Publication. pp.71-81

182 Bakshi, R. et. al. (2007).*Problems of the Aged living with families and in senior citizens homes: A comparative study.* In Indira J.P. (Ed.).Aging strategies for an active old age.7th volume of the Aging and Development Project.CCR-IFCU Publications.p.68.

inLudhiana. The findings revealed no significant difference in the psychological problems of elderly living in old age homes to that of the elderly residing in their own homes. For example , the percentage of aged living with families reported emotional instability (70%), lack of respect (58.3%),worry about financial matters (33.3%), felt isolated and insecure (23.3%), felt useless and idle (18.3%), worry about adjustment with children (61.6%), lack of satisfaction from way of living (13.3%), and family worries as 11.6% respectively, whereas, the corresponding percentage for elderly living in old age home was reported as emotional instability (65%), lack of respect (55%), worry about financial matters (75%), felt isolated and insecure (71.3%), felt useless and idle (63.3%), lack of satisfaction from way of living (46.6%), family worries (3.3%) and homesickness (23.3%). Thus from the above findings, it can be concluded that the 'type of living' does not make a significant impact on the nature of psychological problems, but it does affects the social life of an individual.

Along with the type of living; place of living was also responsible for creating imbalances in the nature of problems associated with senior citizens. To check this Statement, scholars compared the problems of elderly living in rural areas with that of elderly residing in urban areas. For instance, **Surendra Singh**[183]carried out a study to identify the problems faced by rural and urban elderly. The findings revealed that ageing does not constitute any problem for the elderly belonging to rural areas. This is because of the prevalence of joint family system which does not allow aged to lead a lonely life. They continue to undertake light work with smaller recreational demands and hence are better adjusted to the community, whereas, the elderly belonging to urban areas would have faced the problems of poor health, housing shortage and lack of leisure facilities. He therefore concluded that the life of elderly belonging to villages is simpler and tranquil as compared to the life of elderly living in cities.

Similarly, **M. Easwaramoorthy and N.K. Chadha**[184] in their study based on 580 elderly people selected from five districts of Tamil Nadu including Coimbatore, Madras, Madurai, Nilgiris and Thanjavur found that in rural communities the psychological and emotional problems are more severe as compared to their urban

183 Singh, S. (1997).*Psycho-social problems of the aged in contemporary Indian society*. Husain, M.G. (Ed.). Changing Indian Society and Status of Aged. New Delhi: Manak Publications. pp.45-57.

184 Sati, N. P. (1996).*Needs and Problems of Aged: A study for Social Intervention.* New Delhi: Himanshu Publication. p.210.

counterparts. This is due to the impact of migration of their children to urban areas; leaving behind the elderly to face the problem of isolation, boredom, tension and stress. The study also found that in urban areas the elderly suffered more from the problem of environmental pollution, lack of transportation, short electric supply, and the inadequate drinking water. Among the psychological problems; depression, low self-esteem, loneliness and lack of care and respect were reported. Moreover, the urban elderly are found to be better socially adjusted than their rural counterparts. This is because of the factors like income, satisfaction with financial status, health awareness and better leisure activities.

P. N. Sati[185] also conducted a study based on Udaipur and Ajmer to differentiate between the problems of rural and urban elderly and found that the rural respondents prioritized inadequate medical services and falling health as their major concern followed by the problem of lack of respect and feeling of neglect from the family. The urban respondents however ranked the problem of adjustment in living with the family as the most serious problem followed by the problem of social isolation and loneliness.

Following similar line, **Himabindu**[186] carried out a separate study on 200 female elderly belonging to the village of Vishakhapatnam. The findings reported financial crisis as the most severe problem reported by sixty four percent of the female respondents. The reason they cited for economic crisis was their lesser participation in agricultural and related activities. Further, fifty percent respondents reported the problem of sharing responsibility of looking after their children and thirty-five percent reported the problem of loneliness and isolation.

In another study based on the elderly residing in seven villages of Orissa; **S.K. Ghosh Maulik**[187]identified financial problem as the most serious problem experienced by the majority of respondents (sixty percent).The findings also acknowledged a significant relationship existing between the level of income and the age of respondents, as with increase in age 46.9% Oriya and 54.3% Santhal elderly experienced decline in their

185 Sati, N. P, (1996), *'Needs and Problems of Aged: A study for Social Intervention'*,Himanshu Publication, New Delhi, p.210.

186 Himabindu. (2002). *Human Ageing: Study of Rural Women in Andhra Pradesh.* New Delhi: Shipra Publications. p.121.

187 Maulik, S.K.G. (2004). *Life in old age in rural Orissa.*In Help Age India. Research and Development Journal. Vol-10.No. 1. Jan. 2004. p.11.

income. Next to financial problem is the problem of health; as sixteen percent of the respondents reported some kind of health loss.

L.S. Talunkdar and J.A. Menachery[188] also outlined the problems of rural elderly. Their findings revealed that about sixty percent of the respondents felt tense due to non-involvement in decision making of the issues related to division of property and denial of freedom. Almost half of the respondents (48.6%) reported economic hardship. The problem of inter-generational conflict was reported by 55 percent of the respondents, 23 percent reported multiple problems whereas, a drop in health status was reported by almost sixty percent of the respondents. Amongst the common ailments, eighty percent reported the problem of joint pain/arthritis and seventy five percent were facing the problem of lower vision. The other health problems identified were immobility, cough, constipation, sleeplessness, cardiac problems, B.P. problem, diabetes, and cataract.

Similarly, **M. S. Randhwa**[189] made a comparison between the problems of rural and urban elderly. He opined that in urban areas the aged were economically more sound as they had a large number of economic resources like pension, rent from property, and small business etc. whereas in rural areas, indebtedness was noted as the major problem. On health aspects, it was found that both rural as well as urban elderly face similar nature of health problems with some minor variations. For example, the health problems of the rural elderly were noted as eyesight and teeth problems (27%), pain in joints (16 %), eye sight problem (11 %), heart problem (8 %), kidney trouble (9%), Diabetes (4 %), digestive problems (5 %), asthma and skin diseases (6 %), whereas the health problems reported by the urban elderly include eyesight and teeth problem (25%), pain in joints (25 %), digestive problems (10 %), breathlessness (8 %), diabetes (6 %), asthma (7 %), pain in chest (3%) respectively. The findings on the third dimension i.e. the psychological problems revealed that the aged in urban areas (62.2%) are facing more psychological pressures as compared to their rural

188 Talunkdar, L.S and Menachery, J.A. (2000).*Social Work Intervention with the Ageing in rural areas: A Micro- level study in rural Vidarbha.* In Raju, S. S. and Desai, M. (Eds.).*Gerontological Social Work in India: Some issues and perspectives.* New Delhi: B.R. Publishing Corporation. pp.280-284.

189 Randhwa, M.S. (1991).*The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. pp.42-50.

counterparts (50.1%).The reason was the engagement of rural aged in some light work or in gossiping with their peer groups as compared to their urban counterparts.

Thus from the above comparisons, it can be concluded that senior citizens either they belong to lower socio-economic strata or to the middle and higher stratum, either resides in a metropolitan city or in the village; everywhere they have to face some repercussions of old age. However, the nature and extent of their problem may vary depending upon their income, place of living, socio-economic strata and the nature of available resources. Health, psychological and financial problems are found to be the common problems reported by almost all of the senior citizens.

In addition to social and economic dimensions; Health is another dimension which is equally responsible for altering the life of senior citizens. Keeping this in mind, studies highlighting the impact of health on the life of senior citizens were also considered. First, is the medico-social study carried out by **Moneer Alam**[190]on 1000 elderly in the nine districts of Delhi and including both rural as well as urban areas. The major problems reported were the lack of basic health care facilities and acute poverty. A large majority of respondents suffered from curtailed functional abilities and sensory health problems. Moreover, the problem of incapacitation was found to be acute among the lower income groups. Women were reported as the worst sufferers in both the communities.

S. Siva Raju[191] from Mumbai conducted another medico-social study based on 300 urban elderly from three different socio-economic strata and explored poor health as the major problem experienced by the majority. Amongst health problems, the common problems were reported as arthritis, rheumatism, heart problem, high B.P., breathing trouble, eyesight and vision problems. The findings further revealed that almost half of the respondents postponed the medical treatment because of the general belief that old age is an age of diseases, may secure poor health. This shows that they accept many curable sufferings as inevitable and natural.

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190 Alam, M. (2006).*Ageing in India: Socio-Economic and Health Dimension.* New delhi: Academic Foundation. p.257.

191 Raju, S. S. (2002). *Health Status of the Urban Elderly: A Medico Social Study.* New Delhi: B.R. Publishing Corporation. p.5.

In another study, **R. Chakroborty**[192] opined that under nutrition and cardio- vascular diseases emanating from an urban life styles are the two leading causes of death in aged persons in India. **Seema Puri**[193] in her work on "Nutrition: Multiple roles in successful ageing" also reflected nutritional intake of the aged as an important parameter in determining the health status of the aged. The findings revealed that nutritional deficiency may lead to anemia, which in turn, lead to functional disability and loss of working capacity. Nutrition is also linked with longevity and it promotes coronary heart diseases and strokes. Thus there exist a significant relation in between the nutritional intake and positive health of the senior citizens.

In another study based on 230 elderly from seven districts of Meghalaya; **C.J. Thomas and F.T. Diengdoh**[194]developed a positive association in between the health problems and the advancement of age i.e. the health problems increases with age. The study reported that 44% of the aged in the age group of 60-65 years had some health problems as compared to 85% of the respondents belonging to the age group of 80 years and above. Gender difference was also observed in between the health status of male and female elderly as higher percentage of females (65 %) reported health problems as compared males (57 %).In addition, female elderly are found to possess a good psychological status as compared to males. This is because the males suffered more from adjustment problems as compared to their females.

W.H.O's [195]annual report (2000) highlighted ten leading risk factors which affects the health of an individual and especially the elderly including underweight, high/low B.P., unsafe water, poor sanitation, poor hygiene, iron deficiency, high cholesterol, obesity, unsafe sex and indoor smoke from solid fuels.

Therefore, from above findings it could be inferred that the health problems are the real cause of worry for the majority of aged because poor health is related to poor financial status, poor social contacts and finally leading to socio-economic problems.

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192 Chakroborthy, R. (2004). *The Greying of India: Population Ageing in the context of Asia.* New Delhi: Sage Publication. p.283.

193 Puri, S. (2008).*Nutrition: Multiple Role in successful Ageing*. Help Age India Research and Development Journal. Vol. 14.No.1. Jan. Issue.pp.9-15.

194 Thomas, C. J. and Diengdoh, T. F.(2007). *Project report on Ageing in Meghalaya.*ICSSR NorthEastern Regional Centre.Shillong.Meghalaya and Directorate of Social Welfare. Government Of Meghalaya. Shillong (Research Thesis).p.3.

195 WHO.(2002). *World report on violence and health.* Switzerland: World Health Organization. Geneva, Switzerland. Indian Journal of Gerontology. 2008. Vol. 22. No. 3and4, p.267.

Thus need is to focus on health aspects. Further, while designing any policy initiative for the elderly; the government must put health needs on the priority.

Edward. J. Stieglitz[196]too commented on the need of having a good health by stating "health as a privilege, and, as a privilege it entails the equivalent responsibility for its maintenance." He suggested the individuals to take initiatives and maintain their own health because it is the healthy life style that may lead the individual towards healthy ageing.

Parallel to the health problems, are the problems of psychological disorders. Many studies have attempted to develop a link between the two. For example, **N.K. Chadha et.al**[197] in their study based on 200 elderly determined the psychological health of the elderly. The findings reported poor health as the most serious problem encountered by the majority. Further, they identified cardio-vascular disease, arthritis, dental problem, digestion problem, accident proneness, low resistance, lack of adaptability, and mental disorders as the common health problems. The common psychological problems identified were depression, lower life satisfaction, psychological distress, Dementia and Alzheimer's disease. The study found that these mental disorders are not only related to the ageing of brain, but to the losses associated with ageing, compressed QOL and socio-economic problems. Loneliness even in the midst of people was reported by the majority of elderly. This is due to the unavailability of people they can have to relate to themselves.

Similarly, **Gopalji Mishra**[198]in his study identified the major psychological problems of the aged as maladjustment, lack of respect, lack of love and affection from their children and relatives, feeling of neglect, feeling of loneliness and isolation, feeling of being unwanted, feeling of humiliation and dissatisfaction with life respectively.

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196 Stieglitz, J. E. (2005). *The person challenges of Ageing: biological changes and maintenance of Health.* In Prakash, I.J. (Ed.).Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing and Development.p.142.

197 Chadha, N.K. et.al. (2006). *Psychological Health of the Elderly: Age and Gender Issue.* Ageing and Society of Gerontology. Vol. 16.pp 35-49.

198 Mishra, G. (1997). *Ageing: The People's Concern.*In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p.141.

M. Banerjee and D. Tyagi[199] in their study on 'Role adjustment and status of aged' from Shillong based on 123 elderly explored 'isolation' as the major psychological problem observed by the majority. The findings revealed that with advancement in age, more and more people developed a feeling of isolation. He further compared the problem of isolation in males and females. The findings revealed that the feeling of isolation was more prevalent in aged females (79.29%) as compared to their male counterparts (45.98%). Further the study compared the problems in different age groups. Amongst the aged females, the middle-old were feeling highly isolated (17.24%) followed by young-old (10.34%) and the old-old (3.45%). Amongst the aged males, the young-old were feeling highly isolated (7.61%) more as compared to middle- old (4.61%) and old-old respectively.

Similarly, **R. Bakshi**[200] reported psychological problems including worries, tensions and anxieties as the major problems affecting the majority of elder generation. He found a significant relation existing between the psychological problems and the level of interaction among the children and the elder generation. He observed that the psychological problems increases when there is lesser interaction between the children and their parents. Those elderly who are living with their children had developed the psychological problems when they found that their children were not fulfilling their expectations and were disobeying them and also when they leave them behind to suffer from emotional disturbances.

In another study by **N.K. Chadha**[201]based on "Urban ageing: issues and challenges," the similar findings have been reported. The study found that the loss of power and dependency may result in the feeling of neglect, loneliness and unwantedness. The feeling of inadequacy may result when the aged have to be dependent on others for their essential needs either in form of financial support or in terms of instrumental help. Thus the psychological problems are making a significant impact on the overall quality of life of the aged.

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199 Banerjee, M. and Tyagi, D. (2001).*Role adjustment and the status of Aged: A case study of Bengali population of Meghalaya.* In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives.New Delhi: Rawat Publication. p.360.

200 Bakshi.R. (1997).*Adjustment Issues in old age: A case study of Kashmir.* In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p. 61-68.

201 Chadha, N.K. (2003). *Urban Ageing: Issues and Challenges.* In Dey, A.B. (Ed.). Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.94.

Besides physical and mental health problems, the elderly people are also experiencing a depth of social problems. For instance, **Shabeen Ara**[202] in her study based on 250 elderly residing at the slums of Hubli (Karnataka) observed that the Central problem in the life of elderly is the problem of social integration. The aged are segregated from the major structures and processes of modern society, which in turn, make their situation vulnerable. Along with the change in family structure, there are many more factors which affect the adjustment of the aged.

M. G. Husain[203]in his study on identifying the psychological problems of the elderly reported the following factors working behind the poor adjustment of aged as health status, marital status, social status, family relationships, participation in leisure activities, membership of an organization, self-concept, unhappy experiences, self-concept, feeling of permanent security, plans for future, religiosity and belief in rebirth, change in family structure, loss of spouse and problem in utilizing free time.

Gopalji Mishra[204] too discussed some irrational methods that make the social adjustment difficult for the senior citizens. These methods include the denial of ageing, behaving like adults, and overcompensation by becoming intolerant to younger generation, pointing out all defects of youth and claiming many advantages for old etc.

T. Rafiq and N.A. Nadeem[205]in their study based on 400 elderly of Kashmir explored that the problem of social adjustment varied with gender and the type of social adjustment. Males scored higher in health adjustment as compared to their female counterparts, whereas; in social adjustment females take a lead. This is because they get easily adjusted with their children and family. Similarly in marital, emotional and financial adjustments males scored higher than their female counterparts. The problem of maladjustment is even more frequent in retired elderly.

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202 Ara, S. (1994).*Old age among slum dwellers.* New Delhi: South Asian Publishers. p.11.

203 Husain, M.G. (1997). *Psycho-Social Problems of Rural Aged in India.*In Husain M.G. (Ed.). Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p.38.

204 Mishra, G. (1997). *Ageing: The People's Concern.*In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi: Manak Publications. p.143.

205 T, Rafiq. N,A. Nadeem and Husain, M.G. (Ed.). (1997). *Changing Indian Society and Status of Aged.* New Delhi: Manak Publications. p.17.

Similarly, **Saraswati Mishra**[206]carried out her study on retired elderly of Chandigarh and Jabalpur belonging to different socio-economic stratum. The findings revealed a significant relation between the adjustment of senior citizens and their level of financial status. The respondents belonging to the well-off family had shared a satisfactory relationship with the children and other family members as compared to those respondents who are suffering from financial hardships.

In addition to the problem of maladjustment, scholars attached many more problems with the elderly retired from an organization. Hence, the retired elderly form a separate group which needs separate interventions. In this regard, **N.K. Chadha**[207] explored that the retirement leads to decrease in well-being of the elderly. The loss of job due to retirement results in the loss of self-esteem, self-worth, decreased income and activity, and lots of free time.

S. Singh and P.K. Dhillon[208] in their study based on understanding the problems of adjustment of the retired elderly women of Delhi including 150 females highlighted the problems of female elderly as the shortage of money, widowhood, physical weakness, fear of death, mental tension, feeling of social neglect and too much free time to spend.

Similarly, **P.K. Muttagi**[209] in his study based on 200 elderly people residing in Old Age Homes identified the problems of retired elderly as the loss of social status , isolation, dwindling health, loss of prestige, loneliness, isolation, empty nest syndrome, fear of death and dependence, and difference in value systems. He found a significant relationship existing in between the financial status, marital status and the level of adjustment. The elderly having spouse were found to score better in adjustment level than those who are widowed or single. Further, the elderly belonging to the lower socio-economic strata are found to adjust better with the family as

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206 Mishra, S. *Problems and Social Adjustment in old age of the retiree of Chandigarh and Jabalpur.* unpublished research thesis. p.291.

207 Chadha, N.K. (2003). *Urban Ageing: Issues and Challenges.* In Dey, A.B (Ed.).*Ageing in India: Situational Analysis and Planning for the future.* Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.94.

208 Dhillon, P. K. (1992). *Psycho-Social aspect of Ageing in India.* New Delhi: Concept Publishing Company. pp. 2-37.

209 Muttagi, P.K. (1997). *Ageing issues and Old age care: A Global Perspective.* New Delhi: Classical Publishing Company. p.48.

compared to the elderly belonging to higher socio-economic strata because of their involvements in household activities.

M. S. Randhwa[210]in his study based on 180 elderly people discussed the problems of retirees belonging to rural and urban areas. He found that in urban areas the retired elderly had discontinued their occupational role leading to decreased participation in decision making, isolation and neglect, whereas, in rural areas, there is no set pattern of retirement from work and hence they participated more in decision making and other activities. But with rising age; health problems were found to be common in both the societies.

Thus it seems that occupational status or the source of income do have some impact on the health and social status of an individual. Financial crisis was serving as a cause to many other socio-economic problems. For instance, **N.K. Chadha**[211]in his study observed that financial status of elderly was related to their quality of life. Poor the financial status, poor will be its quality of life. This is due to the fact that a clean, pleasant and safe environment was determined by the income. In addition, negative feelings such as fear of crime, poor health, loneliness etc. have also been related to economic status of an individual. Income was also found to be related to the life-satisfaction. Lower the income, lower will be the life-satisfaction; while the reverse is also true.

Surendra Singh[212] observed a direct relationship existing between the social and the financial status. According to him, social status depends upon the occupation and earnings. Any loss in income degrades the social status of the elderly. The unavailability of any continuous source of income creates impediments in the way of discharging varied kinds of social obligations and family responsibilities like that of education of children, employment and marriage of children etc.

Thus it can be concluded that social, economic and health problems are all inter-related concepts. All these are quite visible and forma vicious circle for the senior

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210 Randhwa, M.S. (1991).*The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. pp. 42-50.

211 Chaddha, N.K. (1997). *Ageing and the aged: Challenges before Indian Gerontology.* New Delhi: Friends Publication. pp.108, 147, 207.

212 Singh, Surendra. (1997). *Psycho-Social problems of the Aged in the contemporary Indian Society.* Husain, M.G. (Ed.). Changing Indian Society and Status of Aged. New Delhi: Manak Publications, pp.45-57.

citizens. But this was not the end of miseries for the aged; the senior citizens undergo many more problems which are most experienced but less discussed by the researchers and senior citizens. One such problem is the problem of elder abuse.

A. Venkoba Rao[213]laments elder abuse and neglect as the two important problems affecting the majority of elderly generation. He classified elder abuse in different forms as physical abuse, psychological abuse, material and emotional abuse, neglect and violation of their legal rights.

A.M. Khan[214] in his study based on 364 elderly from Delhi observed that elder abuse is considered as a silent issue because of the reduction in scientific measures to study it although it is the most frequent phenomenon. On looking its impact on the various socio-economic strata, emotional abuse was found to be common in all the three income groups followed by financial abuse and neglect. The study further relates abuse with marital status as all forms of abuse were found as higher among the widows/ widowers and divorcees as compared to the married elderly. A significant relation was also observed in between the economic status and the extent of abuse. The family members belonging to the lower income group were found to be more involved in daily earnings and hence provided no care to the elderly during their sickness. They were fully dependent and hence were more subjected to abuse of different kinds as compared to the independent elderly. Moreover, the study reported that about 56 percent of the respondents would not resort to report abuse.

Thus the main problem in dealing with the cases of elder abuse lies in the identification of abuse. The reasons they cited were apathy of police (36 percent); considering abuse as a family matter (24.5%),felt that it would stop on their own (14.3%), felt guilty and themselves responsible (3%), accepted it as a part of life (3.6%), felt ashamed to report (8.1%), and felt afraid that it would have dire consequences (1%).

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213 Rao, V.A. (2003). *Care of older people: evolution and future prospects.* In Dey, A.B. (Ed.). Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.43.

214 Khan, A. M. (2005).*Empowerment of elderly-Source of healthy Ageing.*In Indira, J.P. (Ed.). Ageing in India: Retrospects and Prospects. CCR-IFCU. Project Report on Ageing and Development.p.142.

U. Bambawale and Streevan's[215]work on 864 females of aged sixty and over from Pune revealed the most prevalent form of elder abuse amongst the aged women. They reported that almost half of the respondents were affected by financial abuse (49 percent). This was due to their financial dependency on their husband, children and other family members. Next to financial abuse was the problem of 'social abuse' as 36.12 percent of the females reported this problem. Social abuse was also associated with poor health, slower movements and loss of social status. Religious abuse was also reported by the widows (5.5%) along with legal abuse (5.5%). This clearly shows that female elderly generally experience abuse of almost all nature.

A.M. Khan and S. Taneja[216] conducted a comprehensive study on three localities of Delhi e.g. New Rajdhani Enclave, Madhur Vihar and Pandav nagar including 384 senior citizens. The basic objective of the study was to identify the various facets of elder abuse. The findings revealed 'financial abuse' as the most prevalent form of abuse followed by social, physical and other forms of abuse. The physical abuse was reported as the rarest form of abuse. Amongst the financial abuse; 31.8 percent observed financial abuse to moderate level whereas, 39.2 percent observed it to mild level respectively. Moreover, no significant gender differences in the nature of abuse was reported as the mean value in almost all type of abuse was relatively similar for both males and females. Regarding the physical abuse, it was found that only one percent faced it to severe level followed by 5.8 % to moderate level .However, 62% of the respondents did not experienced any form of physical abuse.

S. Srinivas and B. Vijayalakshmi et. al.[217] in their study on 140 elderly people of Vishakhapatnam labeled 'verbal abuse' as the most frequently observed phenomenon as eighty-one percent of the respondents confirmed this type of abuse. This was followed by the problem of physical abuse (22.9%), neglect (52.9%) and material abuse (37.1 %) respectively. The study also reflected a significant relation existing in between the nature of abuse and marital status. The widowed elderly were found to be subjected to verbal abuse (84.1%) more frequently followed by physical abuse

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215 Bambawale, U. and Streevan.(1996). *Abuse of the Aged.* In Kumar, V. (Ed.).Ageing: IndiaPerspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology, India.pp.299-301.

216 Khan, A. M. and Taneja, S. (2006). *Elder Abuse and Medical Care.* Ageing and Society Journal. Vol. XVI. No. I and II. pp. 11-34.

217 Srinivas, S. and Vijayalakshmi, B. et. al. (2001).*Abuse and Neglect of Elderly in families.* Indian Journal of Social Work.Vol. 60.No. 3.July. pp. 472-475.

(30.4%), neglect (43.9%) and material abuse (41.3%) respectively. The similar percentages for the married respondents was reported as verbal abuse (74.5%), material abuse(37.5%), neglect(29.1%) and physical abuse (10.8 %).The findings further revealed that the dependent elderly are found to be subjected to abuse more as compared to those who are totally independent. On looking into the abusers, the study reported that son was the most frequent abuser (53.8%). Further, more male abused the elderly (37.9%) as compared to the females (33.3%) e.g. husbands abused their wives (33.3%) more as compared to their wives (in 4% of the cases).

Shubha Soneja[218]in her country report for WHO entitled as 'Elder abuse in India' based on 58 elderly and 16 professionals (PHC workers) working with elderly reported that the issue of elder abuse was avoided by the majority of respondents. Although the elderly talked about emotional problems, neglect, feeling of insecurity, loneliness, loss of dignity, maltreatment and disrespect by the family, but not a single person was willing to label it as 'abuse'. On being forceful about the issues of physical abuse, they denied the existence of such happenings in the community. The avoidance of the issue clearly points out that elder abuse is still considered as a social stigma. Many times the older parents themselves justify the 'abuse' in the existing circumstances by blaming it on the changing scenario, value system and not just to their homes. They were found to be sympathetic to their children either due to emotional bonding or due to the belief that their children will carry the "name" of the family into the next generation. Another interesting finding reveals that the care workers meant for elderly care do considered elder abuse as a social problem and not a health care issue. Hence, they ignored reporting the cases of elder abuse with them.

Thus old age is always confronted with a multitude of problems whether social, physical, health or financial; all are inter-related. Studies do confirmed this relationship. For example, **D. Paul Chowdhary**[219] in his study reported that the problems of elderly are not only inter-related but they form a vicious circle. He opined that failing health may stand in the way of getting employment to the elderly which may further creates an atmosphere in the family in which elderly feel

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218 Soneja, S. *Elder Abuse in India: Country Report for World Health Organization.* New Delhi: Help Age India. p.4.

219 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications, pp. 100-101.

neglected. This further led to loneliness which in turn may give rise to the feeling of depression and worsening of health.

Similarly, **K. Dandekar**[220]conducted a study on 300 rural elderly people of Kerala to identify the problems of senior citizens. The findings do revealed that the problems of elderly are inter-related. According to her "the problem of old age is mainly the problem of poor, deserted and lonely old people. The lonesome are at the same time the poorest and clockwise the poorest are most frequently with the worst material living, health and emotional problems." The main problem highlighted was the protection of the household of the elderly. This is because with rich household, children usually do not leave their parents completely and not even their relatives do that. In addition, difficulty in running an Estate, health protection, everyday help and care identified as the other problems. Above findings indicated that the problems of elderly are multi-dimensional and hence a multi-pronged approach is needed for its reprisal.

The problem of senior citizen ranges from social, health, financial aspect to that of emotional, physical and psychological, thereby covering almost all spheres. But knowing the problem without knowing the cause is useless from the point of view of scientific enquiry. The correct solution to these problems lies in the analysis of the root causes behind the vulnerability of aged. Hence, in the remaining part of this section, the factors related to the vulnerability of aged were discussed.

In this regard, **K. Chattopadhyaya and I.H. Khan**[221] opined that the forces of industrialization, urbanization and modernization have contributed their share equally in aggravating the psychological problems of elderly. These developments have put the younger generation, moving towards town and cities, giving way to nuclear families, working couples and children overburdened with their studies and hence, leaving elderly feeling neglected, lonely, and uncared for.

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220 Dandekar, K. (1996). *The Elderly in India.* New Delhi : Sage Publications. p.10.

221 Khan, I.H. (1997). *Reflections on Ageing in Indian Context.* In Husain, M.G. (Ed.) Changing Indian society and status of aged. New Delhi: Manak Publications. p.60.

In another study, **D.Paul Chowdhary**[222]analyzed the impact of these forces. Further, on checking the impact of individual forces; it was found that the force of industrialization has brought unprecedented pressures in urban areas like the housing shortage; serving as a constraint for staying in common residence with their children and migration; which affects the old who stay behind after their children went out for employment and may face economic hardship and the problem of care. It may further results in the breaking up of joint family system. Modernization, on the other hand, brought the change in the family size and lifestyles, which in turn provide less caregivers and no place for aged. He further highlighted the factors which are making the life of female elderly vulnerable including, the patriarchal nature of the society, inferior diet and cloths, widowhood, and migration of rural males to cities. Thus all these factors are responsible for making the life of the elderly vulnerable.

Pushpa Rani [223]acknowledged 'technological advancement' as the major factor working behind the vulnerability of aged residing in villages. This is due to the fact that the rising technology has brings tremendous changes in the life-styles and values of the younger generation, which in turn, reduces the dependence of younger generation on the elderly. Technology is further responsible for providing better job opportunities to the younger generation and hence promoting migration of youth towards the cities. Excessive migration may even lead to narrow households and lack of space for elderly in cities and hence they are left unattended at villages.

N. S. Saxena[224] identified 'economic incompetence' as the major factor running behind the quality of life of the aged, which in turn, determines the level of their vulnerability. The economic incompetence forces family to avoid giving proper and regular treatment to their parents as per their requirement, which in turn, enhances everyday difficulties of the aged and reduces their social security.

In order to check the consequences of migration on old age; **S. Devi and A. Bagga**[225] conducted a comprehensive study based on 700 Meethi population that showed their

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222 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications. pp.100-101.

223 Rani, M. P. (2001).*Institutional care of the aged.*In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives.New Delhi: Rawat Publication. p.313.

224 Saxena, N.S. (1999). *crime and violence against the aged.* In Bali, P.A. (Ed.) UnderstandingGreying People in India. New Delhi: Inter India Publications. p. 271.

225 Bagga, A. and Dayabati, D. S. (2006).*Ageing in Women.* New Delhi: Mittal Publications. p.13.

migrated to the rural areas of Manipur and Guwahati. The findings suggest that the forces of industrialization, urbanization, social morbidity, growing individualism and easy communication facilities are all playing a significant role in transforming the traditional way of life. It also hampered the traditional ties and emotional links. With the migration of younger people to cities, the breaking up of joint family system was observed, which in turn makes the elderly feeling isolated and discarded.

Sarah Harper[226], on the other hand, lamented that the elderly people are susceptible to a range of factors which makes them vulnerable and move them 'up' in the agenda of development. These include: poor health, frailty, inadequate or inaccessible health services, landlessness, lack of family support, limited skills and capital to invest in productive activity, and low social status.

Similarly, **R. Chakroborthy**[227] explored that the impoverishment of elder people is largely due to deprivation, discrimination and exploitation by the powerful agencies; including the State, with regard to employment and ownership of land and other assets, which these people were subjected to, since the early and formative years of their life. Study also highlighted the breaking up of joint family system as the major factor working behind the vulnerability of aged. This is because family was considered as the fundamental unit of traditional welfare system.

P.V. Ramamurti[228]reported the breakdown of joint family system as the major reason behind the vulnerability of aged. The nuclear family provides fewer caregivers to the dependent elderly. With more women seeking employment outside, the concept of elder care may become a serious policy challenge in future.

C. S. Kart[229] **and S. Harper**[230]in their respective studies highlighted the benefits of family care by stating the fact that a family provides economic security, social care,

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226 Harper.S. (2006).*Ageing Societies: Myths, Challenges and Opportunitie.* New York: Oxford University Press, p.210.

227 Chakroborthy, R .(2004). *The Greying of India: Population Ageing in the context of Asia.* New Delhi: Sage Publication. p.228.

228 Ramamurti, P.V. (1997). *The Psychological Scenario of the Elderly: Problems, Priorities and Perspectives.* In Husain, M.G. (Ed.).Changing Indian Society and Status of Aged. New Delhi:Manak Publications. pp.28-29.

229 Cary, S. K. (1994). *The Realities of Ageing: an Introduction to Gerontology.* Fourth Edition.Library of Congress Cataloging. USA. p.223.

230 Harper.S. (2006).*Ageing Societies: Myths, Challenges and Opportunities.* New York: Oxford University Press. p.236.

and basic health care facilities to the elderly along with psychological support. It also provides a wide ranging kin-based social network required for their social interaction. In return, older people help them to keep the family together and maintain links with near and distant relatives. Thus 'family care' comes out as the appropriate solution for the dependent elderly.

Jill Quadagno[231]too confirmed the fact that strong familial relationships are bringing lesser economic problems and emotional support to the elderly. According to him, "in joint family system, the aged continue to enjoy their status. They retain ownership of their property. Family acknowledges the care of their elderly parents as their duty and neglect as a family disgrace". Therefore, the elderly people preferred to stay in family environment, even if the option of residing in old age home was available.

Recently, the change in family composition was observed in terms of nuclear family system. In this regard, **D. Devi and A. Bagga**[232] reported that the forces of urbanization and modernization are all working behind this change. The shift to nuclear family causes loss of role for older persons as head of family, and thus to decision making and financial autonomy.

According to **A. Bali. and Sharma**[233],"there are many demographic trends which are responsible for diminishing the capacity of families to provide care , namely, rise in education, delaying of the age of marriage, smaller family size ,and life expectancy. As a result of these factors, the families experience care giving as a financial, physical and social problem". Hence, the breaking up of joint family system is generating many other problems for the elderly generation.

Knight and Lesley Anne[234] in their article on "Older people in humanitarian crisis: forgotten generation" highlighted the gender differences in the distribution of services. They found the situation of female elderly as more severe as compared to the males. Further amongst the female elderly; the condition of rural women was found to be more severe as compared to their urban counterparts. This is due to their economic

231 Quadagno, Jill. (1999). *Aging and the life course: An introduction to Social Gerontology*. Tata McGrewHill.

232 Bagga, A. and Dayabati, D.S. (2006).*Ageing in Women.* New Delhi : Mittal Publications. p.15-16.

233 Bali, P. A. (2001). *Care of the Elderly in India: Changing Configuration.* Shimla: Indian Institute of Advanced Studies. pp.138-140.

234 Anne, L. K. (2000). Article: *Older people in humanitarian crisis: Forgotten Generation.* World Today Journal.Vol. 56.No. 8.Aug-Sep. pp.12-13.

dependency on the informal sector for livelihood. Further due to illiteracy, they were not even aware of the benefits and schemes launched for them.

Arun P. Bali.[235] In his study based on rural aged too confirmed the vulnerability of female elderly as compared to their male counterparts. The reasons behind their vulnerability were reported as the lesser access to public resources, the religious belief that scarce resources go first to men, poor nutritional intake, unsatisfactory reproductive care, continuous work and physical violence etc. Further, it results in unsatisfactory health conditions, cultural and social barriers to women's advancement at work, migration of male members to cities, and the employment of women in unorganized sector.

In the light of above findings, it can be concluded that the problems of elderly are multidimensional. They ranged from inadequate health to social, emotional, psychological, physical and financial well being. However, the nature and extent of each problem may vary depending upon the cultural, social and physical aspects. Besides, many socio-demographic factors like industrialization, urbanization, and migration are also contributing their significant share in making the life of the aged vulnerable. Hence, it would be a dire negligence on the part of researcher if the ways through which their problems can be minimized were not identified. The next section, therefore, deals with those studies which had attempted for identifying the possible interventions and coping practices for senior citizens.

(SECTION THREE)

Every individual has its own capacity to cope with problems, including the senior citizens. This section deals with those capacities and behaviours which are practiced by the senior citizens in coming out of their problems. Present section also reflects the interventions adopted by the government and the private sectors (NGOs) in dealing with the problems of the aged. In general, 'coping' signifies not just capabilities or competencies, but part and parcel of one's life long experiences. It deals with all those patterns which an individual used to bring change in his own life.

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235 Bali, P. A. (2001). *Care of the Elderly in India: Changing Configuration.* Shimla: Indian Institute of Advanced Studies. pp.138-140.

L. R. Castro and G. R. Castro[236]however, defined coping as 'the ability to face and deal successfully with the various hardships one is confronted within old age'. It reflects the ways individuals come to be in the world. Here, emphasis is on the unique forms of living that each person produces along his life cycle. Hence, coping mechanisms become crucial in old age, when it seems that to enjoy life depends on the richness, plasticity and openness for new and unforeseen situations. Plasticity here means the possibility of taking up various and multiple forms. Therefore, human plasticity refers to the potentiality of change and deals with instability at all times rather than adhering to an ideologically sustained form of stability.

Like the multidimensional nature of the problems, the coping mechanisms too varied from individual to individual and from society to society. **Sajjan Singh**[237] in his study highlighted coping practices of ancient time and proved its worth in the present context as well. He reported that in ancient time, the coping practices were more inclined towards the psychological satisfaction rather than physical one. This is due to the fact that psychological adjustment plays a big role in coping with old age problems. Hence, the ancient elderly generally accepted yoga, meditation and exercise as their major interventions against the various problems of ageing. Yoga was even used for overcoming the problems of mental and intellectual stress as it helps in getting out of the false identifications of fear .This fear can be of their desires remaining unfulfilled, of being ignored by family or of the fear of death. It will further help the senior citizens in getting established with their own identity. Generally, senior citizens face stress and depression as a result of their social, economic and health problems. They had no outburst and hence are more frustrated as compared to other age groups. Thus stress reduction techniques should be identified and may put on priority.

K. Pappathi[238], in his study based on rural female elderly from Tamil Nadu highlighted yoga, physical exercise, music, relaxation ,medication, psychotherapy,

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236 Castro, L. R. and Castro, G.R. (2001).*Coping in Old Age: Considerations from the point of view ofcase studies from Brazil.*In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives.New Delhi: Rawat Publication. pp. 182-185.

237 Singh, S. (1996).*Coping with Ageing: The ancient way.*In Kumar, V. (Ed.).Ageing: IndiaPerspectives and Global Scenario. Proceedings of the International Symposium on Gerontology andSeventh Conference of the Association of Gerontology. India. pp.226-229.

238 Pappathi, K. (2007). *Ageing: Scientific Perspective and Social Issues.* New Delhi: A.P.H. Publishing Corporation. pp.13-17.

healthy lifestyles , adequate exercise and meditation as the effective strategies to cope up with stress and anxiety amongst the senior citizens. The findings also revealed an inverse relationship in between the stressors and the amount of social interaction. Those elderly who had a regular and healthy interaction with their family and friends were subjected to lesser stress and anxiety. Defense mechanisms like denial, repression, sublimation, humour and anticipation were also suggested as effective strategies.

P.K. Dhillon and S. Chhabra[239]in their study on "Coping strategies across socio-economic classes" of Delhi based on ninety senior citizens; tested coping strategies of stress using Westbrook's Scale. The scale covers 30 items under six coping strategies including action, control, escape, optimism, seeking interpersonal help, fatalism, and passivism respectively. The findings revealed that the aged belonging to the lower socio-economic strata makes the maximum use of seeking interpersonal help (86%) followed by fatalism (82%), and escapism (73%). They employ 'optimism and action' to a moderate degree and 'control' to the least degree. This implies that the lower social class seeks to take help, comfort and sympathy from others. The middle class employ mostly the strategy of 'seeking interpersonal help (75.15%) and 'action' (74.94%). This was followed by the use of 'fatalism and passivism' (67.53%), 'control' (52.3%), 'optimism and escapism' (31.67%). This implies that the aged of this class seeks help from their relatives, friends and professionals along with the actions and efforts they make in order to identify the cause of the problem and the ways of coping. The aged belonging to the higher socio-economic class employed the strategy of 'optimism'(87.57%) followed by the strategies of 'seeking interpersonal help'(81.85%), 'control'(71.65%),escapism(63.23%) and 'action'(62.37%) to a higher degree. Further, the strategy of 'fatalism and passivism' was also employed to the moderate level (i.e. 52.33%).

This implies that the aged of this class have a tendency to remain optimistic and cheerful about the future and don't worry unduly w.r.t the present and the past. They talk to their friends and relatives about their problems and seek advice and sympathy. They also control their feelings and the situation, by accepting the limitations and compromising. To test the level of frustration, she extended her sample size to 240

239 Dhillon, P. K. (1992).*Psycho-Social aspect of Ageing in India.* New Delhi: Concept Publishing Company. pp.171-173.

including both males and females in the age groups of 30-40 years, 40-60 years and 60 and above. The study compared the level of frustration in the three age groups by using Tiwari's Frustration Test of 1972. The findings revealed that the people coming in the old age category are facing more the problem of frustration as compared to the other age groups and they generally use 'regression' as a coping mechanism to deal with their problem of frustration.

P. V. Ramamurti[240] in his study on "Ageing and stress: Strategies for coping" based on 400 elderly from middle-socio-economic strata of Chittor District; identified that the problem of stress originates from the stressors. The stressors also varied with the problem. For example, money, status, property and retirement may serve as a stressor for socio-economic problems. For physical problems, the stressors include weakness, immobility, sensory loss and chronic diseases. Similarly, the stressors for psychological problems include the feelings of dependency, loneliness, helplessness, death, insecurity and anxiety. The stressors for familial problems may include relocation, bereavement and intergenerational conflicts.

The psychological stress was found to be the most common problem among the senior citizens followed by familial, social, physical and financial stress. The individuals with low stress scored high on social support, values and life outlook and scored low in death anxiety and frustration. Therefore, coping to stress is largely an individual matter and the one who possessed the aforementioned qualities were able to cope better with stress.

Cary S. Kart[241] classified coping strategies against the life-stress into two broad categories, namely, behavioural strategies and cognitive or emotional strategies. Behavioural strategies include a wide array of actions that individuals can employ to change or alleviate stress. Personal resources like finances, education and social support may also be drawn in a stressful situation to provide help. The cognitive/ emotional strategies implies the ways in which individual may employ his social and psychological mechanisms to deal with stress. It includes the social interaction with the family and society.

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240 Ramamurti, P.V. (1996). *Ageing as stress: Strategies for coping*.In Kumar, V. (Ed.).Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology. India. pp.216-217.

241 Cary, S. K. (1994). *The Realities of Ageing: an Introduction to Gerontology*. Fourth Edition.USA : Library of Congress Calaloging. p.189.

George Lawton[242]determined the involvement of aged in various arts and crafts as an effective strategy in coping with their psychological problems. He suggested activities like the art of cooking, art of gardening, art of eating, art of sharing oneself, and the art of creating love and belonging etc. These activities not only carry extraordinary potentialities for emotional adjustment; but will provide a positive source for the expression of their anger, emotions and other feelings.

A.B. Dey and N. Kumar[243]in their study based on Counselling of senior citizens reported counselling as an important method for dealing with the psychological problems of elderly. Counselling was suggested because an older person needs the opportunity to talk and to have a listener. The counselling can be used in various forms like counselling to relieve distress, leisure time counselling, spiritual and marital counselling, interpersonal counselling for repairing the interpersonal relations, group counselling for bereavement and addictive behaviour, and problem solving counselling for maladaptive behaviour etc.

Following similar trend; **Kaushik and Chadha**[244] developed a psycho-social model to highlight the problems faced by the elderly along with their coping mechanisms. The model suggested for the adoption of a complete holistic view to overcome the psychological problems and hence improving their QOL. For this re-education, counseling and acting as a catalyst with the elders were suggested. The model further suggested for developing certain programmes which can actively involve elders in community life as teaching aids, library assistance, guards at crossings, drivers etc. Some programmes should also be framed for the elders to utilize the missed opportunities in life in the best possible ways. These programmes should also educate the aged persons to change their life-style making themselves aware w. r. t. personal needs, expressive behavior, taking initiative to accept the role of negotiation if they have grievances. Hence the model suggested having an advanced planning for keeping the psychological problems away.

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242 Lawton, G. (1951). *Ageing Creatively.*In Clark, T. (Ed.).Living through the older year.University of Michigan Press.p.127.

243 Dey, A.B. and Kumar, Nimisha. (2003). *Counseling the older person.* In: Dey, A.B. (Ed.) Ageing in India. New Delhi: Rakmo Press Pvt. Ltd. pp. 249-256.

244 Kaushik, S. P., Srivastava, D.N. and Chadha, N.K. (1997).*Improving Quality of life among elderly.*In N.K. Chadha (Ed.). Ageing and the Aged: Challenges before Indian Gerontology. New Delhi: Friends Publications. pp.205-212.

P. K. Muttagi[245] opined that the strategies used by the older people in coping with psychological problems must be seen in a broader framework including family structure, kinship group and neighbourhood ties. The study reported that those who are having intensive and regular interactions with relatives and friends, those who are staying within the family structure and keep close contacts with their sons are all found to be in a better condition to cope in comparison to those who live alone or have social contacts of lesser degree. Social contacts not only helps in having better network participation and social interaction but also strengthens the personal ties of the aged.

The relevance of social contacts and social networks was also highlighted in many studies dealing with the problem of loneliness and depression. For example, **Shabeen Ara**[246] lamented that the social interaction with the family, kinship group and neighbourhood will serve as an effective coping strategy in dealing with the problem of depression and loneliness. In another study of similar nature; **K. Pappathi**[247] pointed towards "social interaction" as an effective coping strategy against the problem of loneliness and depression. Social interaction here includes the interaction with the family members, friends and relatives. It was observed that the rural aged has lack of resources and hence interaction from their own family helps them in overcoming the problem of depression and loneliness.

Social interaction was also reported as beneficial in case of elderly residing in urban areas. For example, **Savita Vermani**[248] opined 'social interaction' as an effective tool in coping with the problem of loneliness because in urban areas, the children often ignored their parents; they even spend lesser time in interacting with them. As a result, they developed the feeling of disrespect and loneliness which can be minimized only by having a kind of social interaction with relatives and friends.

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245 Muttagi, P.K. (1997). *Ageing issues and Old age care: A Global Perspective.* New Delhi: Classical Publishing Company. p.41.

246 Ara, S. (1994).*Old age among slum dwellers.* New Delhi: South Asian Publishers. p.18.

247 Pappathi, K. (2007). *Ageing: Scientific Perspective and Social Issues.* New Delhi: A.P.H. Publishing Corporation. p.19.

248 Vermani, S. (2006).*Changing pattern of interaction and interrelation of elders in family.* Ageing and Society. Indian Journal of Gerontology. XVI (IV) 15-30.

Similarly, **K.R. Gangadharan**[249] confirmed the social integration as an effective tool in overcoming the psychological problems of senior citizens. The findings revealed that the older people who are more socially integrated are enjoying better health. In addition, family reunions, family celebrations, being with friends and participating in important events, involvement in senior citizen associations, joining music groups and spending time in games and other physical activities were reported as other effective strategies for creating social integration. **K.D. Gangrade**[250] also commented on the concept of social interaction by stating that "the strong network relationship is a key to the problems of ageing in India. It is the family and social networks which mould individuals and all the aspects of life including- social, economic, religious and political aspect".

Anupriya Mallick[251] in her study on "Dealing with loneliness in elderly" explored many strategies working effectively in coping with the problem of loneliness including to keep busy, helping others, involving in community affairs, avoiding escapes like day-dreaming, too much sleeping, watching too much television, choosing to be happy, collecting good thoughts, poems and literary masterpieces, and finally joining a social group or society in the community.

S. L. Hutchinson et.al[252]in their study on "The Red Hat society: Beyond fun and friendship" aimed at identifying the reasons behind the joining of a society found social interaction, although achieved by joining any social group or society, as helpful in coping with the problems of old age. The Red Hat society was also serving as a coping resource to many of the elderly as it was responsible for providing social support, emotional regulation, sustained coping efforts and meaning focused coping. On finding the reasons as why people join the society, it was found that sixty five respondents joined the society for overcoming the chronic stressors associated with the death of their spouse. It was helping fifty-four people in meeting their medical needs. It had provided care-giving to twenty one respondents, reduced stress of

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249 Gangadharan, K.R. (2005). *Future of service and advocacy for older person in India.*In Indira, J.P. (Ed.), *Ageing in India: Retrospect and Prospects.*CCR-IFCU.Project Report on Ageing andDevelopment.p.40.

250 Gangrade, K.D. and Bose, A.B. (1988).*The Ageing in India: Problems and Potentialities.* New Delhi: Abhinav Publications. p.46.

251 Anupriyo, M. (2006).*Dealing with Loneliness in Elderly.* HelpAge India-Research and Development Journal. Volume 12.Number 3.October.pp. 32.

252 Susan L. H. , Careen M. Y. Julie, S. and Deborah, L. K. (2008). *Beyond fun and friendship: the Red Hat Society as a coping resource for older women.* Ageing and Society-28. pp. 979-999.

seventeen respondents helped thirteen respondents to cope up with the empty nest and provided chance to seventeen respondents to have a break and recharged. Hence, by joining Red hat society, the elderly reduced many of their psychological, social and emotional problems.

Mathew Kaplan and N.K. Chadha[253] while searching for better coping mechanisms against the reduction of intergenerational gap observed "intergenerational programming" as the most appropriate solution. Intergenerational programming, addresses the familial, community and societal problems of the aged. It aims at bringing the generations together by improving relations and promoting collaborative efforts.

In addition to individual efforts, many NGOs are also working on the concept of making the life of elderly easier. For instance, **Aastha Foundation**[254], an NGO based in Delhi, started a programme in which the elderly people adopted a community and educate youngsters about local traditions and festivals. The NGO also initiated "the slow learner children's programme' in which the elderly people attached themselves to the private schools and taught the slow learner students after the school hours on one-to-one basis. As a result, the elderly and the younger participants perceived each other as the surrogate grandchildren and grandparents. Hence, it brings the revitalization of social and emotional links in their lives. It also helped in coping with the problem of depression and loneliness as it became an effective way of passing their leisure time.

Based on somewhat similar concept, **Help age India**[255], a Delhi based NGO, has initiated 'Adopt a Granny' and 'Join hands campaign' in which attempt has been made to reunite the aged and the younger generation. In 'Adopt a granny' programme, the school children were send to select a locality and the elderly residing over there and thereafter visiting them on a regular basis. During the visits, they were taught to share love and affection with them. In 'Join hands campaign', the people of all ages were sensitized on issues related to the care of elderly. They learn to see the ageing

253 Chadha, N.K. and Kaplan.M. (2007).*Intergenerational programmes and practices: A conceptual framework and an Indian context.* In Sharma, K.L. (Ed.). Studies in Gerontology: Intergenerational Perspective. New Delhi: Rawat Publication. p.11.

254 www.justdial.com/Delhi/astha-foundation-percent3Cnearpercent3E-ranjit

255 Help age India :Research and Development. Journal.Vol. 15.issue 3.October 2009.

process as a positive phenomenon and not a burden. They were also encouraged to show an active participation in the process of development.

Similarly, another NGO **'The Help Foundation'**[256]is offering recreational facilities to the senior citizens in the form of opening 'Dada-Dadi Clubs'. The NGO is running more than one hundred such clubs in the various parts of India with an objective of providing basic amenities to the elderly like A.C. rooms, telephone facility, canteen, music systems, drawing and painting equipments, computer rooms with Internet facility, medical facilities etc. The basic motive of running these clubs is to engage the aged in various kinds of social activities and get them back to retain their lost respect and confidence. The NGO is also providing Dada-Dadi parks in which the aged spend their leisure time in an eco-friendly environment and share their memories with their friends and peer groups.

The Harmony for Silver Foundation[257]**,** an NGO, is providing the benefits of an 'Interactive Centre' to the elderly for improving the overall quality of life of the senior citizens. In these Centres; the elderly generation got some free space to interact with their peers and experience life in their own way. The Centre offers a wide range of services including yoga, laughter club sessions, health checkups, treatment facilities, organization of cultural and spiritual events in the society etc. Thus NGOs are also making tremendous efforts for enhancing the social interaction among the aged.

Following similar path, **D. Jamuna**[258] also suggested few interventions meant for promoting the intergenerational interactions amongst the aged and the younger generation. The foremost is the educative interventions in which the family and the aged persons would be counselled towards building the favourable attitudes; whereas the care givers and the care receivers would be educated to improve their interpersonal relations. The other strategies include the provision of incentives to motivate the family members; inculcation of the values of altruism, humanism, generosity and collectivism; and finally the incorporation of the values of caring and

256 www.thehelpfoundation.org/

257 www.harmonyindia.org/hportal/aboutus.jsp and www.askme.com/...harmony-for-silvers-foundation /

258 Jamuna, D. (2001). Intergenerational Issues in Elder Care. In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.294.

sharing with the aged in school curriculum. Hence, it could be concluded that a plenty of researches are now available on the identification as well as on the removal of psychological problems of the aged.

Parallel to psychological problem is the problem of physical and mental well being.

In this regard, **R. N. Lakhotia**[259] in his study based on self-disciplined lifestyle management reported that the follow up of self-disciplined lifestyles would help in the achievement of excellent health. Self-disciplined lifestyles include exercise; follow up of regular routine, nutritional diet, eating of eighty percent alkaline and twenty percent acidic content, drinking of fresh juices before half an hour of meal, spiritual positive attitude and proper relaxation etc.

The psycho-social model of **Kaushik and Chadha**[260]do suggest the following interventions in coping with the health problems of elderly e.g. a brisk walk early in the morning, regular practice of yoga to improve the blood circulation of body, toning up of muscles, proper nutritional intake with adequate fluid in the form of milk, butter, lemon water and fruit juices, proper medical checkups and treatment. Hence, the model strictly suggests for following healthier life styles for securing good health.

K. Chauhan et.al[261]in their study based on 60 females from middle income group of Vadodara city had tested the impact of educational programme of nutritional intake on their health. The basic objective was to check the impact of nutritive education on the dietary habits of the senior citizens. The findings revealed that before the intervention, the overall prevalence of Anemia was 96%. Further, 75% of female elderly had poor knowledge regarding nutritional disorders, 43% of the elderly were unaware of the fluid intake, and only 12% of the respondents consumed the supplements of iron. Further, among the age groups; the young-old elderly group had better knowledge regarding the benefits of exercise in old age (31%) as compared to the old-old age group (11%).However, after the intervention, 9% of the respondents reported improvement in the knowledge about external changes in old age,14% had shown

259 http://rnlakhotia.net

260 Kaushik, S. P., Srivastava, D.N. and Chadha, N.K. (1997). *Improving Quality of life among elderly.*In N.K. Chadha (Ed.). Ageing and the Aged: Challenges before Indian Gerontology. New Delhi: Friends Publications. pp.205-212.

261 K. Chauhan et.al. (2009). *Study on Knowledge and Practices of Elderly Female Self Care Givers: Capacity Building through Nutrition Health Education (NHE) Intervention.* Help age India: Research and Development Journal. Vol. 15. Issue 3. October 2009.

improvement about physiological changes, 63% had improved their knowledge about medical problems, 17% reported improvement in knowledge regarding dietary care in various diseases, 43% had raised their awareness regarding recommended fluid intake, and 30% reported improvement in knowledge regarding the benefits of exercise in old age. Thus, Educational interventions have shown a positive impact on knowledge regarding the various aspects of health. Thus from these findings it could be inferred that the aged need to be taught more regarding the healthy practices and their benefits.

Following similar line, **H. B. Ferrari**[262] in her study on "Vitamin D supplements prevent falls and fractures" based on Zurich reported that the nutritional intake of an elderly person do affects his/her health. The findings revealed that the supplementation of Vitamin D can help a lot in the reduction of the problems related to bones and muscles. The study reported twenty percent reduction in non-vertebral fractures along with the reduction of eighteen percent in hip fractures by the intake of high doses of Vitamin D in the respondents. The correct range of vitamin D consumption per day for elderly people was thereby suggested as between 482 IU/day to 770 IU/ day.

Similarly, **Seema Puri**[263] reported the avoidance of many diseases like Anemia, Osteoporosis, Hip fractures and Alzheimer's disease because of the proper intake of nutrients. Hence, nutritive diet is considered as a good supplement for improving the quality of life of the aged.

Many NGOs are also making efforts to search for some effective ways of healthy ageing. They even started with services like care giving, Medicare, Counselling, formation of SHGs etc. For instance, **Help age India**[264], a national NGO, has initiated 'Project Kiran' in Cuddalore district to provide 'Palliative care' to the patients whose disease is no longer responsive to curative treatment and life expectancy is relatively short. Till recently, 36,397 cataract surgeries were conducted under 67 projects. Another project 'Karuna' was initiated as a pilot project in 2008 and is now running

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262 http://dx.doi.org/10.1136/bmj.b3692 and www.bmj.com/content/339/bmj.b3692(Published 1 Oct 2009)

263 Puri, S. (2008).*Nutrition: Multiple role in successful Ageing*. Help Age India Research and Development Journal,Vol. 14.No.-1. Jan. 2008. pp.9-15.

264 www.helpageindia.org/

in eleven villages in the East Godavari district of Andhra Pradesh. The project has provided medical services to nearly seventy percent of the target population. Under this programme SHGs were formed at each level to provide individual and group counselling. Besides, it promotes awareness and access to services and resources. Another major programme was 'MMU Programme'. Help age India has the largest network of Mobile Medicare Units in Asia with having 54 MMUs, running in 19 States .By 2008 , The MMUs organizes 375 health camps in different locations where 9,68,462 patients have been treated. These MMUs are providing basic health care services, physiotherapy, physiological therapy, shelter assistance, disability aids, and counselling and multi-specialty camps. Thus all these efforts, either taken by the NGOs or by the planners pointed towards the need of having an integrative approach for the overall well being of senior citizens.

K. R. Vaidyanath[265] in his study 'Towards Healthy Ageing' listed the following strategies being capable in ensuring healthy ageing: vigorous exercise, walking, yoga, balanced diet and healthy sleep habits. While pointing towards the impact of these strategies; the study reported that the aged who used to burn 15,000 calories per week had experienced twenty-five percent lower death rates than those who burn less. The findings further suggests that simple walking may even improves the heart and lung functions, strengthen bones, control weight, and put the breath back into the lungs. Similarly Yoga tones up the body. Balanced diet increases the resistive power of the body. A good night's sleep for about 5 to 6 hours in the night and a ten minute catnap in the afternoon were leading the elderly towards a healthy and successful old age.

Vinod Kumar et.al[266]in their study on 'Healthy Ageing' identified that the functional ageing is the most appropriate form of ageing and to achieve this level; the following strategies are required: the prevention and control of chronic diseases, healthier life styles, appropriate physical activity and optimal dietary habits. Out of all these measures, the optimal dietary habit was reported as the most suitable. This is because the disease prevention through dietary management is not only cost effective but also remains in one's own control. The study recommended the balanced diet required for

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265 Vaidyanath, K.R. (2002). *Towards healthy Ageing*.In Vaidyanath, K.R. (Ed.).Ageing with Dignity.New Delhi: Reliance Publishing House. pp.94-102.

266 Kumar,V. and Miguel ,Acanfora. (2001). The Journal of Rural Health Volume 17. Issue 4. Pp. 328–331. September 2001.

an elderly person in a day for both male and female elderly as cereals(350 gm for M and 225 gm for F), pulses(50 gm for M and 40 gm for F), vegetables(200 gm for M and 150 gm for F), roots and timbers(100 gm for each), fruits(200 gm for each), milk and milk products (300 gm for both), sugar(20 gm for both) and fats(25 gm for M and 20 gm for F)respectively.

Similarly, **A. Husain and S. Maqbool**[267] in their study on ' Successful Ageing: Planning through healthy life styles' highlighted the following lifestyles as helpful in achieving successful ageing e.g. social interaction, adjustment, enhancement of self-esteem, enhancement of happiness, regular mood induction, pleasant activities, cognitive therapy, social skills training, balanced diet, health maintenance, residential facilities, and prioritization of household tasks and responsibilities.

In another study, **S.S. Hasrani and S. J. Shabu**[268]also reported regular exercise, proper eating, stress control, learning of first- aid, adopting safety habits, personal health behaviours, being an informed consumer, protecting the environment and managing time effectively; as the most appropriate healthy lifestyles following which the senior citizens can delay ageing. The study further suggested these life styles for not only helping senior citizens in disease prevention but also in improving their quality of life. These lifestyles further prevent worsening of vision and hearing, heart and lung problems and drying of skin and wrinkles. Therefore, these life styles should be followed by all senior citizens on a priority basis.

P.C. Krishnas and A.R. Aghababa[269] in their study on 'Productive and practical life styles and strategies for healthy ageing' also recommended similar kind of strategies as helpful in reducing the aggravated loss of health. These includes eating fruits in abundance, eating raw and organic vegetables, using natural sugar, preferring butter to ghee, avoiding preserve food and drinks, adding natural proteins in the form of sprouted corns, eating sugarcane, avoiding water in between the meals as it dilutes digestive enzymes, strictly avoiding alcohol and wine, physical exercise and

267 Husain, A. and Maqbool, S. (1993). *Relationship of sensation seeking motive to death anxiety and alienation among substances abuse inpatients.* Journal of Psychological Researches-37. p. 57-61.

268 Shabu, S.J. and Hasrani, S.S. (2007).*Life Style for Healthy and Dignified Ageing.* In Indira, J. P. (Ed.).Aging strategies for an active old age.7th Volume of the Aging and Development Project.CCR-IFCU Publications. pp.79-80.

269 Krishnas.P.C. and Aghababa, A.R. (2007).*Productive and practical life styles and strategies for healthy ageing.*In Indira J.P. (Ed.). Aging strategies for an active old age' 7th volume of the Aging and Development Project. CCR-IFCU Publications.pp.3-5.

activities, attending and adopting programmes like yoga, meditation, listening to music and maintaining friends, adopting personal strategies of planning a routine, gardening and warm up, engaging in reading after breakfast, taking some rest in the afternoon, having a long walk in the evening, moderately sharing negative thoughts, playing with kids and helping them in home work etc.

In another study of similar nature, **A.B. Dey and Nimisha Kumar**[270] prioritized life review therapy and follow up of religious pursuits as the effective strategies in coping with the health and psychological problems. The life review therapy involves the elicitation of an extensive autobiography from the older person, and of the family member, if needed. Therapy has a definite structure and is characterized by the progressive return to consciousness of past experiences, and in particular the resurgence of unresolved conflicts. The therapy helps in the reorganization and re-integration of these conflicts. Religion, on the other hand, was found to be a powerful tool in developing faith and enhancing hope for the future. Thus, the follow up of these two strategies would result in developing a positive attitude towards life.

K. Pappathi[271] also recognized 'religion' as a means of providing emotional, social, spiritual and psychological security. According to him religion gives consolation and strength to face misfortunes. Further, a positive correlation was found in between religious activity and feeling of happiness and life satisfaction.

Similarly, **Arjun Rastogi**[272]in his study on "spiritual values to cope with ageing" explored religion as an effective tool in coping with the fear of death. The study reported that the persons who used to realize the transient nature of physical reality, who appreciates the eternal character of the soul, and who knows that their actions can change the final outcome of their spiritual station are in a better position to cope with fear of death. Every religious person looks forward to death as a chance to get reunited with the loved ones in the spiritual world of god and not as a fear. Hence, religion prepares them to accept their failing health and bodily limitations and serves

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270 Dey, A.B. and Kumar, Nimisha. (2003). *Counselling the older person.* In: Dey, A.B. (Ed.) Ageing in India. New Delhi: Rakmo Press Pvt. Ltd. pp. 249-256

271 Pappathi, K. (2007). *Ageing: Scientific Perspective and Social Issues.*New Delhi: A.P.H. Publishing Corporation. p.21.

272 Rastogi, A. (1996). *Spiritual Values to cope with Ageing.*In Kumar, V. (Ed.) Ageing Indian Perspectives and Global Scenario. New Delhi. AIIMS.p230.

as an effective strategy of dealing with the psychological and emotional problems in old age.

In a similar line, **Sajjan Singh**[273] in his study on "coping with ageing: the ancient way" introduces the significance of spiritual dimension in coping. According to him, the spiritual dimension is the substratum on which the other three dimensions stand and without this, one cannot even think of coping with the problems of ageing. Religious practices may shift one's own identification from body, mind and intellect to the 'self', which in turn develop a kind of psychological evolution, the only way to cope with old age.

In addition, **P. Chakrabarti and U. Biswas**[274] hold the view that spiritual counseling may serve as an effective tool in coping with the problems of old age. Spiritual counselling can be provided by family, friends, community and religious leaders in terms of encouragement towards the chanting of the name of god, reading out of religious passages, allowing them to visit the nearby holy centers and by providing a common place for meditation.

The above findings therefore reflect that in old age one has a lot of alternatives to choose for acquiring a good health. But all these alternatives require thorough planning and a holistic approach. The findings further pointed out the fact that the old age problems are interrelated. The root cause of health problem lies in poor economic conditions. This is because the financial constraint does not allow senior citizens to go for proper treatment. Hence, to understand health aspects, one has to check the financial aspects as well. The next category of problem is therefore the financial problems and the coping practices were related to the same.

In this regard, the Psycho-Social Model of **Kaushik and N.K. Chadha**[275] highlighted the following mechanisms to deal with the problem of economic hardship e.g. involvement in teaching and writing, doing light job and business like poultry

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273 Singh, S. (1996).*Coping with Ageing: The ancient way.*In Kumar, V. (Ed.).Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology, India, p.230.

274 Chakrabarti, P. and Biswas, U. (2007).*Elder Violence in Kolkata: A Content Analysis.* Indian Journal of Gerontology. Vol.17. No.IandII. pp. 14-15.

275 Kaushik, S. P. Srivastava, D.N. and Chadha, N.K. (1997). *Improving Quality of life among elderly.* In N.K. Chadha (Ed.). Ageing and the Aged: Challenges before Indian Gerontology. New Delhi: Friends Publications. pp.205-212.

farming, looking after nursery, running a preparatory school, or working as a consultant . All these activities will help senior citizens in spending their free time along with helping them in coping against the increasing cost of food, clothing, shelter, transportation and healthcare. The model also suggested the government/ semi- government firms to introduce long term benefits to its employees so that the elder generation will get some mental satisfaction and support.

Similarly, **M.S. Randhwa**[276] in his study based on 360 respondents selected from both rural and urban areas reported financial crisis in both the localities (43.3% rural and 29.4% urban).When they were asked about the ways of coping with financial crisis; the rural respondents reported that borrowing money from money lenders, commission agents or the co-operatives are their best alternatives at the time of financial crisis. Some reported that they cut down their expenditures according to their needs. But in most of the time the cut was spent in their medical expenses. In urban areas, most of the respondents took help from their sons. However, almost equal number of respondents reported that they cut down their expenditures and very few of them reported that they withdraw from their savings.

Similarly, **P. O. Sijuwade**[277] carried out a study focusing on the coping practices adopted by the elderly against the economic problems. The study was based on 300 elderly from Lagos belonging to lower socio-economic strata. The findings revealed that majority of the elderly were reported to have some financial crisis in their life as only 32% of the elderly were involved in economic activity, 9.7% had some savings and almost half of them were dependent on their children for their needs. In order to come out of these problems, 32.3%of the respondents reported that they try to keep their expenditure within their income only by curtailing their needs and wants, 22.05% reported to seek assistance from their children, relatives and friends. Further, 7.3% reported that they borrowed money from money lenders. However, a very small percentage (0.7%) reported that they utilize their savings from their past earnings. In addition, 37.75 of the respondents reported that they got solace and comfort during economic crisis by practicing the religious activities and believing in God.

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276 Randhwa, M.S. (1991).*The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.3.

277 Sijuwade, O. P. (2008). *Coping with the economic problems in old age and civil society's response to it.*Pakistan Journal of Social Sciences 5 (7). Pp. 691-695.

In addition to individual coping mechanisms, the government and non-government initiatives have also been introduced to overcome the problem of financial insecurity amongst the aged. For example, the government is providing Old Age Pension to all those who have crossed the age of sixty and have no one to look for. Similarly, many NGOs are providing monetary help in terms of old age pension. For instance, **The Help Foundation**[278]is providing Dada-Dadi pension of worth Rs. 500 per month to the senior citizens who are not having any source of income and are dependent on others. **Help age India**[279], in order to tackle the growing financial insecurity of aged, had started 'Reverse Mortgage Scheme' in collaboration with the national housing bank. Under this scheme the lending institution makes periodic payments to the senior citizen or borrows against their property, thereby turning the property into a source of steady cash flow during their lifetime. Presently, the Help age has started counseling centres in Delhi, Hyderabad, Kolkata and Chandigarh to provide details about the scheme. The NGO is also running a programme named 'Elders for elder's movement' in Gujarat, M.P., U.P., and Jharkhand with an objective to mobilize the elderly to form SHGs. These SHGs initiate savings for exploring livelihood opportunities and strive for their rights in the existing social welfare and development schemes. Till 2009, Help age has formed 259 such SHGs covering 3,560 members, opened the bank accounts of 250 SHGs with overall savings worth Rs 1.82 lakh. The NGO also provides financial assistance to the aged by organizing 'health insurance camps'. Till 2009, more than 50 insurance camps had been organized in ten districts covering 5,160 elderly. In addition, it organized Vridh melas to provide services and organized advocacy workshops to sensitize non partner civil society organizations to widen their agenda for the elderly.

E. W. Burgess[280] in his study on "The growing problem of ageing" came across an interesting finding that the financial problem is more common amongst the elderly retired from any government job. This is because with retirement they face many imbalances in the personal way of living and hence it leads to maladjustment. Burgess suggested many ways through which the elderly can came out of this maladjustment. First is the re-orientation of attitude. In old age; the rigidity in attitude was found to be

278 www.thehelpfoundation.org/
279 www.helpageindia.org/
280 Burgess, E. W. (1951). *The growing problem of Ageing.* In Tibbitts, C. (Ed.).Living Through the Older Years.University of Michigan Press.pp-18-19.

a common characteristic. The retired person often refuses to face reality of necessary adjustments to be made with reduced income. Thus re-orientation of attitudes was found as favourable. The second way to readjustment was the adaptation or modification of activities to meet declining physical vigor and reduced income. Third way is to take friendly advice and professional services by the wife, friend, physician, pastors and counsellors.

Indira Jai Prakash[281] in his study on "Strategies for ageing in place" identified few more strategies for achieving the goal of healthy ageing. These include the opening of day care centres and townships. Day care centres were suggested to provide the recreational activities to the aged. It also serves as a meeting place to the elderly where they can easily share their problem with their friends. But the only drawback found in choosing this option is the high cost. Thus living in one's own residence is the best option for the aged belonging to all income groups and especially to the lower socio-economic strata. However, the family was considered as the first priority by every aged but the need of old age home was never ignored.

Many NGOs are also providing housing facilities to the aged. For example, **Dada-Dadi Help Foundation**[282]is providing the scheme of 'Dada-Dadi Ashram' to senior citizens in overcoming the problem of housing. These ashrams are being set up at Vrindavan, Haridwar, Navi Mumbai and in all religious places along with the capitals of each State and to provide premium housing with ultra-modern facilities to senior citizens at affordable prizes. These ashrams comprised three star comforts including food, water, security, electricity, Internet, Direct to Home facility, medical checkups and treatment by professionals etc. 'Herbal gardens' are also maintained for ensuring healthy environment to senior citizens. **Help age India**[283]is also providing shelters to many in terms of old age homes and is working towards the move of transforming the old age homes into the composite shelters. These shelters go beyond providing simply a roof and meeting the basic needs of the elderly.

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281 Prakash, I.J. (2000). *Issues in Mental Health and Psychological wellbeing of older person.* In Raju, S.S. Desai, M. (Eds.).Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p.26.

282 www.thehelpfoundation.org/

283 www.helpageindia.org/

After housing, the next serious issue of consideration is the problem of "elder abuse". Elder abuse is affecting the senior citizens like a silent killer. In this regard, **Chakraborty and Biswas**[284] carried out a study in Calcutta and reported the following interventions as essential in combating the cases of elder abuse e.g. round the clock helpline by local police station, keeping healthy connection with neighbours and friends, registration of domestic servants with the police, avoidance of making contacts with unknown persons, avoiding the discussion of property and other assets in public, and joining the clubs or schools to serve those who are in need.

Similarly, **Usha Bambewala**[285] identified the provision of legal literacy, formation of support groups, bringing changes in the attitudes of the youth towards the aged, and making children aware of the exchange theory as few other initiatives that can help the elderly from getting abused.

Shubha Soneja[286] also explored involvement in some constructive and light work, setting up of recreational or day care centres , providing free counselling and legal help, providing financial and psychological support to the families as some important measures that may reduce elder abuse to some extent.

In addition, NGOs are also intervening at local and national level to combat the problem of elder abuse. For instance, **Dignity Foundation**[287] has introduced "Project Helpline: Security with dignity" in Mumbai and Chennai to have a check on the number of cases of crime and elder abuse. Through this project some volunteers have been sent to every locality to identify the incidence of elder abuse and reported them to the police. The basic objective here is to take preventive measures or avert the untoward incidents.

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284 Chakrabarti, P. and Biswas, U. (2007).*Elder Violence in Kolkata: A Content Analysis.*Indian Journal of Gerontology.Vol.17. No.1and11. pp. 14-15.

285 Bambawale, U. and Streevan.(1996). *Abuse of the Aged.*In Kumar, V. (Ed.).Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology andSeventh Conference of the Association of Gerontology. India. p.301.

286 Soneja, S. *Elder Abuse in India; Country Report for World Health Organization.* Help Age India. New Delhi-110016, p.4.

287 bhrc.bih.nic.in

Another NGO, **Help Foundation**[288]was making efforts to sensitize the masses against the issues of elder abuse by publishing a monthly newsletter "Dada-Dadi Times". The newsletter focuses on all the problems and needs of senior citizens.

Help age India[289] is also making sustained efforts towards the awareness generation of elder abuse. The NGO influences the policy makers to bring an environment conducive and beneficial for the elderly, whether through raising awareness about elder abuse or inculcating value education on 'agecare' in school curriculums. The basic aim is to sensitize children about age care issues early in their life. In order to give a public platform and identity to elder abuse; the NGO organizes many value education seminars across the different parts of the country. Help age is also working on the concept of help lines. The first help line was launched in 2004 as '1253' in Delhi and had rescued 1000 elderly till September 2009. Recently, it was expanded to Cuddalore, Hyderabad, Mumbai, Chennai, Shimla and Bangalore with upcoming launches in Bhopal, Dehradun and Kolkata. The basic objective of help line is to listen the voices of elderly in need. The help line provides information on access to various elderly schemes and linkages with the government; police and rescue services. It also provides counselling services to elderly in distress. Some help lines tied up with local shelters to provide much needed assistance, care and protection to the elderly in need.

Mumbai Police[290]has also initiated "Samman" a helpline in 2004 to serve elderly living in isolation. The police registered all the senior citizens and volunteers through post, through website of Mumbai police and through dialing '1090'. After their registration the police try to search for their problems and provide solutions. Thus initiatives like helplines, free counselling etc. may work effectively in case of elder abuse.

Kalyan Bagchi[291]in his study on 'Healthy Ageing' lamented education by mass awareness as an important strategy for ensuring healthy ageing and sensitization. While citing the benefits of education, he stated that "an educated individual may

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288 www.thehelpfoundation.org/
289 www.helpageindia.org/
290 ncbi.nlm.nih.gov and www.mumbaipolice.org/
291 Bagchi, K. (2003). *Ensuring Healthy Ageing: Some Concerns*. In Dey, A.B. (Ed.). Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. p.54.

become aware of their vulnerabilities". He also suggested many strategies for mass sensitization including the use of media for information, education and communication and individual and group communication through lectures, workshops and discussions.

Ravindra Kumar[292] in his study on "Education for older people: a social action agenda" recommended the following interventions as necessary against the elder abuse including awareness sensitization, media intervention, information support regarding the coping , developing partnership networks, focusing on the component of "art of living", publicizing and keeping the concerns of older people in public focus; foster multidisciplinary collaboration among institutions and other agencies, working on issues and policies concerning older people, developing and delivering appropriate educational and training materials, providing information for older people and preparing sufficient database for help in policy making etc.

Like academicians, many NGOs are also working for identifying the channels of communication through which the senior citizens can be streamlined. For example, **Harmony for Silvers foundation**[293], an NGO, has introduced a separate website "www.harmonyindia.org" to create networking and awareness about the needs of the elderly. The website highlighted the available resources and opportunities for senior citizens. NGO is also publishing a magazine called 'Celebrate Age' to highlight the issues of senior citizens. Thus from above initiatives it could be said that education is serving as an effective strategy in dealing with the problems of senior citizens.

Along with education, many studies highlighted the need for empowering the elderly. For instance, **P.V. Ramamurti**[294] in his study on "Empowering the older persons in India" recognized that the problems of elderly can be dealt only by the way of their empowerment. According to him, "empowerment does not imply the possession of power but being able to use it effectively to one's advantage. Through empowerment, one is able to cope up with their problems in a more efficient manner. For elderly, the

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292 Kumar, Ravindra. (2003). *Education for Older people: A Social Action Agenda.* In Dey, A.B.(Ed.). Ageing in India: Situational Analysis and Planning for the future. Ministry of Health and Family Welfare. New Delhi: Rakmo Press Private Limited. pp. 197-199.

293 www.harmonyindia.org/hportal/aboutus.jsp and www.askme.com/...harmony-for-silvers-foundation /

294 Ramamurti, P. V. (2003). *Empowering the older persons in India.* Help Age India–Research and Development Journal. 9(2). 5-8.

term empowerment implies 'control' over the three spheres of life namely financial, social and health". He also suggested short and long term measures to cope with the old age problems e.g. for financial problems, the short term measures were suggested as involvement in productive work, expansion of old age pension for destitute, provision of incentives to the caregivers, and construction of more old age homes, whereas, the long term measures includes the provision for compulsory savings across the life span, encouragement of citizens to develop immovable assets from which they can draw a regular income etc.

Similarly, to cope with the health problems, the short term measures were identified as the availability of easy medical facilities like the mobile Medicare, development of geriatric ward at district hospitals, equipment of PHC through in service training of staff and supplementary medical facilities, creating public awareness on geriatric problems, whereas, the long term measures involved the adoption of a life span approach of disease prevention and health promotion, development counselling initiated from early years, internalization of appropriate motivation to learn about health and hygiene. Similarly, the short term interventions against the social problems were reported as the strengthening of existing familial support by family counselling, creating awareness towards personal and social effectiveness, creating motivation, organization of community responsibility and action programmes to help the elderly, whereas the long term measures include a gradual attitudinal change to recreate a favourite disposition towards the elderly and education of children to give respect and care to the elderly persons.

In addition, many studies pointed towards the need of having Social Work interventions for empowering the senior citizens. Following similar objective, **M. A. Hossen**[295] reported the following strategies as effective in the empowerment of elderly under Social Work practice: collectivization of elderly in a small group to present them as an ideal model for empowering others; establishment of a dialogical relationship by sharing information; direct involvement of elderly in decision making; provision of information on the role of agency and their rights; consciousness raising on issues of common concerns and advocacy on elder issues respectively.

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295 Hossen, Abul. M. (2005).*Empowerment based Social Work Practice: Issues and Challenges.* Indian Journal of Social Work.Vol.66. No. 224. pp.196-210.

In another study based on 146 pensioners of Gulbarga (Karnataka), **Gangadhar B. Sonar**[296] identified the following roles of a Social Worker as essential within the family and institutional setting e.g. the role of an advocate, evaluator, broker, teacher, consultant, mobilizer, behaviour changer, community planner and caregiver. For socio-psychological problems, here commended for giving Case Work and Group Work interventions.

Similarly, **D. Paul Chowdhary**[297] suggested various roles that a Social Worker can perform for the elder welfare including the role of a caseworker, to focus on the individual problems of the aged; the group worker, to focus on the relationship between the aged and their family and to reduce isolation, loneliness, powerlessness and anonymity; the enabler, to help the aged in identifying and altering their own environment and provide information; the broker, to serve as a link in between the client and community resources; the advocate, to become the spokesman of the elderly; and the expert, to offer his own expertise , knowledge and skills for helping the aged. In addition to these roles , some specific interventions were also identified as effective in empowering the elderly like in case of terminally ill persons; provision of mobile dispensaries, access to health centres, supplementary nutrition through 'meals on wheels' programme, provision of aids, organization of social and religious activities, provision of recreational activities like low cost movies, day care centres, library and reading rooms, provision of opportunities for community services like adult literacy, looking after sick, tuition to children, helping them in managing investments and tax exemptions, and counselling services to overcome isolation and helplessness; are recommended.

Following similar line, **L. S. Talunkdar and J. A. Menarchery**[298]in their study on "Social Work intervention with the ageing in rural areas" from rural Vidharba reported that the Social Work interventions could not be generalized and can be made on the basis of the specific problem. The study reported that in rural areas the majority

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296 Sonar, G. B., and Til, K. M. (2004).*Problems of the Aged: A Social Work Study in Gulbarga District of Karnataka.* Social Problems: Perspectives for Intervention. p.365.

297 Chowdhary, D. P. (1992).*Aging and the Aged: a source book.* New Delhi: Inter India Publications. p.106.

298 Talunkdar, L.S and Menachery, J.A., (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation.pp.288-291.

of aged undergoes the financial crisis (48.6%). Hence, the formation of Self Help Groups (SHGs) was suggested as the suitable intervention. These SHGs can be assisted by providing raw materials and loans on easy terms and rates. The findings also revealed that the elderly did not know the legal implications and procedures of a 'will' for transfer of property after death. Thus Social Worker may intervene by conducting legal aid campaigns in the villages, with special focus on property matters. Similarly, to overcome the social problems, organization of various religious ceremonies and tours were suggested. The study also highlighted the absence of value based education among the youth as the major cause behind the elderly neglect and conflicts in the family. Therefore, the introduction of condensed courses for the youth which covers physical, emotional and social aspects along with the needs of the elderly was recommended.

In another study, **Sneh Lata Tondon**[299] while describing the Social Work interventions found that the role of a Social Worker will change according to the change in situation and hence changes the intervention. For example, a Social Worker can play the role of a case worker while handling the individual problems and provide Counselling on issues related to anxiety, fear of death, legal help, management of investments, tax exemptions, arrangements for the payment of electricity and phone bills and other necessary obligations etc. whereas, while working with the groups of aged, social worker can provide therapeutic, occupational and recreational services including involvement of elderly in various group activities like Group discussion, music, games and excursions, helping families who are willing to keep their aged members with them in multi problematic situations by providing monetary help and supportive services like visit of nurses under their supervision etc. For those elderly who are living alone, Social Worker must organize services like "Adopt a Granny" and offering accommodation to young people as paying guest to elderly's residence etc. The worker may also provide some steady income along with companionship. The worker may also perform some special roles in specific situations e.g. in old age homes, it is the Social Worker who help in determining the suitability of the person for admission to institution by conducting home visits and interviews with the aged and the family; prepare elderly before hand to minimize their anxiety and

299 Tondon, S. (2006).*Senior citizens: perspectives for the new millennium.* New Delhi: Reliance Publishing House. p.19.

apprehensions; initiate interactions among the inmates and staff; and help the institutional staff in identifying their needs and potentialities. In community, the Social Worker must advocate for the change in perception of general public towards the aged. It also advocates for social security benefits for the larger sections of the society. Hence, Social Worker may work as a coordinating agent with a multi-faceted approach.

Sushma Batra[300] in her study from NCT of Delhi comprising 300 elderly on "Health problems of elderly: an intervention strategy" highlighted some Social Work interventions in combating with the health problems of elderly including awareness generation for regular medical checkups, early detection of diseases, training of both indigenous and allopathic doctors to handle the specific illness, setting up of subsidized health care with special units in hospitals, providing ambulance and mobile services, awareness about nutrition and health related issues through booklets, CDs and banners etc.

In another study,**V. E. Richardson and A. Barush**[301] from U.S.A. discussed the stages of Gerontological practice along with the role of a Social Worker. The stages were identified as the listening stage, assessment stage and the intervention stage. The listening stage deals with building rapport and trust, helping clients accept, and control their feelings, assisting clients in identifying stressors in their life and finding meaning to it. Thus listening empathetically and expressing cultural empathy were suggested as the effective roles for a Social Worker in this stage. However, in the assessment stage, the ABCDEF Practice framework served as an effective tool in identifying the client's Actions; Biological and health factors; Cognitive functioning and coping styles; Demographic effects(age, gender, marital status etc); Environmental forces and community resources. In the final stage i.e. the intervention stage, the Social Worker may apply specific (micro and macro) intervention techniques based on client-centered, practitioner centered or collaborative approach. The study recognized "Integrated Practice Model" as the ideal model for the practice of Social Worker. This Model emphasized on the recognition of the multiple factors

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300 Batra, Sushma. (2005). *Health problems of elderly: an intervention strategy*. Indian Journal of Gerontology.Vol. 18.No. 2.pp.201-218.

301 Richardson, V. and Barusch, A.S. (2006).*Gerontological Practice for the 21st Century: A Social Work Perspective.* Columbia University Press. pp.208-231.

in the assessment and intervention. This model assumed that adoption of integrative practices will help the elderly in diverse backgrounds. For example, in dealing with the problem of elder abuse, the following integrative methods were suggested e.g. collaboration with other professionals at the time of evaluation, linking family members with the appropriate community service, encouraging family members to socialize with friends, and finally, getting engaged in religious activities.

Hence, from the above discussions it can be concluded that either we consider individual coping or the interventions made by the government and private sectors(NGOs); what is needed is the 'integrative approach' with having special focus on the specific problems and needs. Interventions should be need based and must directed towards the concept of achieving "Successful or Active ageing". The word "active" here refers to the continuing involvement of older persons in social, economic, spiritual, cultural and civic affairs and not just the ability to be physically active. Thus "active ageing" in total signifies "the process of optimizing opportunities for physical, social and mental well-being throughout the life course, in order to extend healthy life expectancy, productivity and QOL in old age".

Today the need of 'active ageing' has been recognized by almost every nation. **WHO**[302] in its discussion paper "Health and ageing" reported three pillars of active ageing as health, productivity and protection.

Hui-Chauan Hsu[303] from Taiwan explored some reasons as to why the concept of active ageing is important. This is because it helps in getting physically fit, being independent, having no chronic disease, and feeling cared for by family and friends, becoming an active participant in the community events, keeping a job, and getting engaged in productive activities etc.

According to **A. M. Khan**[304] 'the concept of active ageing is very new and the elderly themselves have to fight for their own battle if they want to come out of the older concept of passivity and non-productivity. They need to realize that they are capable

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302 www.who.org/

303 Hsu, H. C. (2007). *Exploring elderly people's perspectives on successful ageing in Taiwan.* Ageingand Society. 27(1). 87-102.

304 Khan, A. M. (2005).'*Empowerment of elderly-Source of healthy Ageing'*.In Indira, J.P. (Ed.). Ageing in India: Retrospects and Prospects. CCR-IFCU. Project Report on Ageing andDevelopment.p.142.

of managing themselves and their surroundings. However, good health care, proper utilization of leisure time, enough social participation and cordial relationship with members of family and neighbours, and developing positive attitudes towards life are some strategies which can add cheer to the life of an individual and makes his ageing successful'.

P. Patil and V.Gaonkar[305]in their study on "Ageing Happily" reported that ageing happily and gracefully is in one's own hand. For this, one needs to be specific and must follow healthy life styles. In a nutshell, all interventions are either suggesting or are influenced by the concept of active or healthy ageing.

The overall genesis of above literature review suggested that the aged population still constitutes a vulnerable section. They had confronted with problems related to almost every sphere including social, economic, health, psychological, physical and emotional well being. Although, a depth of literature is being available on ageing and its related issues touching almost every sphere, but still, a wide gap between the researches relating the identification of interventions with the problems was observed. Mostly, the studies presented elderly as a vulnerable group and ends with identifying their socio-economic problems. However, very few reported elderly as an asset and discussed their achievements. The young scholars and NGOs are also showing lesser interest in undertaking big research projects on ageing. This is because of the lesser resources and lesser availability of funds.

The severity of ageing literature can be analyzed by simply looking into the fact that there is no authentic source available for aged at the national level from where one can locate the exact position of senior citizens. Besides this discrimination, the elderly generation faces the burden of declining health, reduced physical vigor and diminishing potential to earn. The forces of urbanization, industrialization and modernization are further aggravating their problems in terms of breaking up of joint family structure, housing shortages and care giving problem. Keeping this in mind, the present research is designed to highlight the problems of the aged with a scientific

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305 P, Patil, and V,Gaonkar. (2006). *Ageing Happily*. In Prakash, I.J. Aging with Health and Dignity. A Book of Abstracts of Asian Regional Conference of Aging and Development. Department of Psychology.Bangalore University. Bangalore. 9 -11 February. p. 94.

approach. Attempts have been made to identify those methods that will help the professionals in deciding their plan of actions.

2.4: Statement of the Research Problem:

Elderly people constitute a forgotten generation. There are many needs of senior citizens which remain unmet and untouched by the Government and policy makers. The young scholars are even showing lesser concern towards this age group. Besides, the elderly face individual problems like reduced physical and mental strength, decline in coping practices and poor financial status. In addition, the changes produced due to the forces of urbanization, industrialization and westernization makes their condition even more critical. The breakup of joint family system into nuclear family results in the problem of care giving, housing and financial constraints. The women considered as primary care giver, do observe a role shift due to their participation in employment which further aggravated their problem of care giving.

'Ageing within the aged' is another issue of concern as the situation of aged who crossed the age of eighty is even more critical. They had no other alternative left instead of getting dependent on others for their daily activities of living. Similarly, there is rising concentration of female elderly widowed who are facing 'triple jeopardy' i.e. of being women, being elderly and being widowed. Moreover, the elderly residing at the rural areas do not have access even to the basic services of health.

Hence, in a condition like this, few important questions emerge as: what could be done for fulfilling the needs of the elderly generation? Whether we consider ageing population as a stress or a burden to our society? Who will perform the care giving role to senior citizens, if not their children? All these questions look simpler, but they are very important in bringing quality of life for the senior citizens and hence, needed proper justifications. In actual, elder generation is not a burden; they are, in fact, valuable resources. They can contribute equally to the economic and social development of a country; if their experiences and potentials are being fully utilized. This calls for policy makers and researchers to identify innovative roles for them.

The problems of the elderly, not just required a macro level planning but adopting strategies, practices and interventions at the grassroots level is equally essential. Ageing no doubt, is the most negligible area under research. Today we have a depth of studies related to the identification of socio-economic problems of senior citizens, but very few generated the path of interventions and coping practices.

Present study is also designed to identify the socio-economic problems of the elderly but with a difference. The difference lies in the introduction of the positive ways of coping against these problems along with possible interventions. Hence, the study is designed basically to explore the possibilities of achieving healthy ageing. For this, the study focuses on the senior citizens of Aligarh and aimed at **"the identification of socio-economic problems, coping practices and possible interventions for senior citizens of Aligarh (U.P.)"**. Aligarh is chosen because it comprised of a good mix of population having all characteristics. Thus the basic purpose of research is not merely problem identification and description, but also prediction and control. Keeping this broader objective in mind, the following research objectives have been formulated:

2.5: Objectives:

The empirical study had the following research objectives:

- To study the socio-economic profile of senior citizens of Aligarh city.
- To identify the socio-economic and health problems observed by the senior citizens of Aligarh.
- To analyze the coping practices adopted by senior citizens in coping with their socio- economic and health problems.
- To suggest interventions in dealing with the problems as identified in the present study.

2.6: Hypotheses:

The present study proposes to test the following hypotheses:

- Females are more vulnerable than males in terms of their social status, decision making power, nutritional intake, ownership of assets and health status.

- Socio-economic problems increase with age. It is highest in oldest-old than in old-old and young-old age group .
- Social security increases with education. Those with higher education may have more ownership of assets, awareness towards the government schemes, and reliable coping practices.
- Religion serves as an effective tool for coping against distress.
- Migration after the age of sixty may leads to more socio-economic problems.
- Elder abuse is the least reported phenomena in old age.
- Primary caregivers in old age are the spouse and the family members.
- Senior citizens are in a habit of ignoring their health problems.
- The ability to cope decreases with age and hence the old age needs more assistance and support.

In order to test the above hypotheses the following methodology has been adopted.

2.7: Research Methodology

Research methodology is a systematic and orderly way of organizing research. Webster International dictionary [306]defined Research methodology as "a careful critical inquiry or examination in seeking facts or principles, diligent information in order to ascertain something". Thus research methodology provides a systematic way of sample design, data collection, data organization, data interpretation and data analysis. Since the present study is an empirical work related to the socio-economic problems and coping practices of senior citizens, the methodology is designed accordingly to ease both the researcher and the target population.

Research Design:

The research design present study is 'diagnostic-cum-descriptive' in nature. 'Diagnostic' because it determines the frequency and association of one variable with the other. The study attempts to diagnose the causal relations between the variables like education, age, gender, religion and quality of life. The study is 'Descriptive' as it

306 Webster, N. (1970). *A Compendious Dictionary of the English Language: Webster's Third New International Dictionary*. P. B. Gove (Ed.). Bounty Books.

portrays accurately the characteristics of senior citizens. Interviews were conducted formally to describe the life styles, living patterns, patterns of social interactions and coping mechanisms of senior citizens. The study is also an endeavor to link the problems of senior citizens along with their solutions.

List of Variables under study:

The research variables, of any scientific experiment or research process, are factors that can be manipulated and measured. A variable is an entity that can take any value. For the present study, the following variables have been considered: age, marital status, religion, caste, education, type of housing, family size, living space, financial income, financial assets, savings, health problems, mode of treatment, health insurance and helping aids as a means of coping, nature and form of abuse, coping practices and healthy behaviors etc

Operational Definitions:

The following terms have been used under the present study:

- **Senior citizen:**

  Senior citizen for the purpose of this research means any person who is sixty years of age and above.

- **Young-Old:**

  The senior citizens coming in the age group of 60 to70 years.

- **Old-Old:**

  The senior citizens coming in the age group of 70 to80 years.

- **Oldest-Old:**

  The senior citizens holding the age of 80 years and more.

- **Household:**

  Household consists of all persons who occupy the housing unit collectively.

- **Coping Mechanisms:**

  Coping mechanisms includes all those capabilities or competencies that an individual gains from its lifelong experiences and identifications. It deals with individual patterns of dealing with change in the life of senior citizens.

- **Intervention:**

  Intervention means all the efforts and initiatives taken by the professionals especially the social workers, government and other authorities for the welfare of senior citizens.

Universe of study:

The 'Universe' represents the entire population from which a sample is chosen. The universe of the present study is Aligarh city of Uttar Pradesh. Aligarh is in the Western part of U.P. located at 27° 53′ North and 78° 4′ East longitude. Aligarh district is divided into two parts: Aligarh city and remaining area of Aligarh District. The city is further divided into twelve blocks and seventy wards[307]. Aligarh city is famous for its lock industry and internationally renowned Aligarh Muslim University. The total population of Aligarh District is twenty nine lakh and ninety two thousand, whereas, the population in Aligarh city is eight lakh and sixty four thousand. The total population of senior citizens in Aligarh District is two lakh six thousand, seven hundred and fifty three, whereas, the population of senior citizens in Aligarh city is forty nine thousand, two hundred and eighteen. Thus these 49218 senoir citizens constituted the population for the purpose of this research. Applying Krejcie and Morgan[308] which provides that for a population of 1000000 and above, the maximum sample size is 400 and law of inertia, the sample size has been finalized at 500.

Aligarh has been selected because of its smaller size, homogeneous population and researcher's familiarity with the area. At one side, the senior citizens of Aligarh are facing extreme poverty, deprivation and forced denial of bare necessities, whereas, on the other hand, they are more self-supporting, willing to work and have extreme wealth. Thus, Aligarh is an example of Modern Township with a good mix of elderly population belonging to all socio-economic stratums. Besides heterogeneity, Aligarh

307 http://updes.up.nic.in/spatrika/engspatrika/sect_table.asp

308 Krejcie, Robert V. and Morgan, Daryle W. (1970). Determining Sample Size for Research Activities . *Educational and Psychological Measurement, 30: 607-610.*

has been observing rapid pace of urbanization and fast changing socio-economic conditions which also brings many changes in the life styles of elderly and needs examination.

Sampling Design:

Sampling design is a technique of selecting a sample from a given population. In social research, it is the most crucial phase. The basic objective of sampling design is to make the sample representative. According to Wilkinson[309], "Representative sampling design is one which warrants the insurance that the chances are great enough; that the selected sample is sufficiently representative of the population; and that it decreases the likelihood of misleading sample findings." The process of sampling makes it possible to draw inferences or generate on the basis of careful observation of the variables in relation to a relatively small proportion of the population. Thus a sampling design is devised to take into account the level of accuracy and confidence.

Sample size and sampling technique:

The sample of the present study consists of 500 senior citizens. The study adopted 'Stratified Proportionate Random Sampling' technique for the selection of the respondents. For sample selection, the city was divided into five zones that is East, West, North, South and North-East on the basis of Burgess Model[310].The model assumes a relationship between the socio-economic status (mainly income) of households and the distance from the Central Business District (CBD). The further from the CBD , the better the quality of housing, but the longer the commuting time. Thus, accessing better housing is done at the expense of longer commuting times (and costs).At the first stage of sampling; one ward is selected from each zone on the basis of their socio-economic and demographic profile. Moreover, religious concentration was also considered while the selection of a ward. The five wards selected from these five zones were Hamdardnagar, Kishanpur, Shahjamal, Pala Sahibabad and Sir-Syed Nagar. All these wards are densely populated and people are generally reported to share different social, economic and cultural characteristics. For example,Sir-Syed

309 Wilkinson et. al. (1993).*Methodology and techniques of Social Research,* Bombay: Himalayan Publishing House. p.266.

310 http://people.hofstra.edu/geotrans/eng/ch6en/conc6en/burgess.html

Nagar is a posh locality comprising a large number of Muslim population, whereas, Kishanpur is a posh locality mainly comprising Hindus.

On the second stage of sampling, the households containing senior citizens are randomly selected from each ward by using proportionate random sampling technique. Thus the total numbers of households located in all the five zones were calculated as 5,608; out of which 1105 are in North zone ward (Pala Sahibabad), 1160 are in East zone ward (Kishanpur); 982 are in West zone ward (Shahjamal), and 1507 are in North-East zone ward(Sir-Syed Nagar).Details of sample drawn from each stratum on the basis of proportionate random sampling is discussed below:

Let the number of elements in each stratum= (N_h) ; Total population = (N)

The stratum weight (W_h) is calculated as[311]

$W_h = N_h / N$ (where h=1 to 5 ; for ward 3(W_3)= 1105/5,608= 0.197)

Therefore, the number of element to be elected in each stratum (N_i) would be calculated by multiplying the total desired size of the sample (N) by the stratum weight (W_h):

$N_i = N \times W_h$ (where i= 1 to 5; for ward 3; N_3=500 × 0.197=98.51=99)

Thus the sample will be proportionate because the representation of each stratum in the sample is equal to the ratio of that stratum in the population;

$N_h / N = N_i / N$ [for ward 3; proportionality is (99/500)=(1105/5608)=0.197]

Similar procedure is adopted for all the five wards and thus their stratum weight and no of households selected were calculated as shown in table 1.7:

Table 1.07: Table showing the stratum weight and number of households

Stratum Number	Zone	No of total Households(N_h)	Relative Weight of stratum (W_h)	Selected Households(N_i)
1	East	1160	0.206	103
2	West	982	0.175	88
3	North	1105	0.197	99
4	South	894	0.152	76
5	North- East	1507	0.268	134

Thus total sample size (N) = $N_1+N_2+N_3+N_4+N_5$= 103+88+99+76+134=500

311 Cochran, W.G. (2008). *Sampling Techniques*. New Delhi: A.H. Print Pack- third Edn. Wiley India edition. p.89.

Tools and Procedure of data collection:

The present study is an empirical research. The study was carried out on the basis of both primary and secondary data. The primary data was collected through interview schedule and case study. Of which, Interview schedule was the main instrument for research.

Schedule is usually applied to a set of questions which are asked and filled by an interviewer in a face to face situation with another person[312]. Schedule consists of questions printed in a definite order including fixed-alternative and scale items. These questions are logically related to the central problem. The basic motive of designing the schedule was to gain the face sheet information, problem information and the information related to their coping practices. The interview schedule was first pre-tested by the investigator for modifications and finally, with the modified schedule the researcher personally visited the areas selected for the study. Before starting the interview the respondents have been assured that all the information would be kept confidential and used for research purpose only. Each interview lasted for one hour .To get reliable information about the personal details, the researcher try to establish good rapport with the respondents. This Rapport building, through one to one conversation played a significant role in eliciting useful information from the aged and would create an ambience of mutual trust between the researcher and the respondents. The field work lasted for almost nine months. Prior to main visits, the researcher also made an attempt to carry out a preliminary visit. This visit was planned to get familiarity with the area under study and to locate the households.

Further to view the socio-economic problems of the senior citizens in totality and to verify the genuineness of the findings; **Case studies** were conducted. In total, fifteen such case studies were conducted including three from each ward. Case Study method is applied by the researcher to understand the complexity of factors working within a social unit as an integrated totality[313]. Case study specially focuses on all those factors which are working behind the problems of senior citizens in natural setting. During case studies; the respondents shared their life experiences and profiled their problems

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312 Goode, J.W. and Hatt, K.P. (2006).*Methods in Social Research.* New Delhi: Surjeet Publications. p.133.

313 Kerlinger, F.N. (2004). *Foundation of Behavioral Research.* New Delhi: Surjeet Publications, p. 257.

in more refined way. Thus case studies further helped the researcher in investigating the depth of the problem along with their causative factors. Finally, the data collected from the 500 senior citizens from five different wards were scrutinized and processed for analysis.

The secondary data was generated by visiting many national libraries and NGOs located at Aligarh and New Delhi. For official data like census reports and annual reports; the researcher visited district offices of Aligarh and check their annual records. Finally, for getting recent updates; related websites have been searched.

Processing of data:

The data collected for the study was both qualitative and quantitative. The quantitative data was collected through schedule, whereas, quantitative data was gathered through case studies. For analysis of quantitative data, the relevant information on the interview schedule has been organized, checked for inconsistencies, meaningfully coded and transferred to the cards. With the help of these coding cards, the data was then transferred to computer for electronic data processing. Subsequently, using SPSS software; frequency tables and cross tables were prepared. To check the required association between the variables, Chi-square test has been applied. Chi-square test is a statistical test of significance which is used to compare observed frequencies with expected frequencies under a certain set of theoretical assumptions.[314]

Presentation of data:

Presentation of data is the most crucial part of the research. Presentation makes the analysis simpler and easily accessible. For present study, the data collected through the interview schedule was presented in the form of tables. Tabulation was done manually. In these tables, the frequencies and their corresponding percentages have been highlighted. Cross tables were also designed to show the association between the variables.

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314 Foster, J.J. (2006). *Chi-Square Test.* The SAGE Dictionary of Social Research Methods. Victor Jupp.Pub.| ISBN No. 10.4135/9780857020116.

Analysis and Interpretation of data:

The data collected from field (raw data) or processed through tabulation; does not make any sense unless it was analyzed and critically interpreted. Analysis means the categorization, ordering, manipulating, and summarizing of data to obtain answers to research questions. In the present study, the analysis of data was done to make it clearer. During analysis, the researcher analyzed the different characteristics of data and inferred the directions coming out of it. Chi square test has been used to find out the significance and association between the variables.

After analysis, interpretation of data was done. The Interpretation and analysis of each table was shown in a separate chapter. For interpretation; current findings of research were compared with few more studies and theories, if available. Hence at this stage, the researcher understands the real significance of findings and establishes explanatory concepts as to why the observations are made and for what purpose.

Limitations of present study:

The present study acknowledges the following limitations:

- The primary limitation of the study is its restriction to the target groups i.e. the senior citizens. The study would have been more effective if it covered the care givers and other service providers. But due to time constraints, this was not possible.
- At the time of data collection, many of the senior citizens were undergoing some physical ailments and hence the help of significant others have been taken, which leads to intermixing of views.
- During data collection, few of the senior citizens were accompanied by their family members and they were not ready to leave them alone. This hinders the privacy between the researcher and the respondents.
- The senior citizens were not able to sit properly in long settings and hence the time limit for data collection has enhanced.

CHAPTER II

SOCIAL SECURITY MEASURES FOR SENIOR CITIZENS IN INDIA

SOCIAL SECURITY MEASURES FOR SENIOR CITIZENS IN INDIA

Ageing is truly a multi-disciplinary area of investigation and its understanding is facilitated through various disciplines,namely, Anthropology, Sociology, Law, Geriatrics and Social Work.In Social Work, ageing has been dealt under a specialization, namely, Geriatric Social Work. Geriatric Social Worker[1] helps senior citizens live healthier and more productive lives. The Social Work practitioners and the scholars across the World are continuously working towards identifying the needs and problems of ageing. Their basic motive is to design various measures and interventions following which the future generations may age happily. There are many ways through which a Social Worker can help senior citizens e.g. a Social Worker may help in understanding and effectively utilizing the various social services and programs; offer direct assistance; provide family-support services, counselling services and facilitate the coordination of medical care etc.

But all this require a prior knowledge of the available welfare measures. Therefore, the present chapter has been introduced to identify the various schemes and interventions meant for the welfare of senior citizens knowing which the Social Workerand other professionals can help senior citizens in lowering their risks of ageing.

Like every other nation, India too has a well-organized social security system meant for the welfare of its citizens, including the aged. Therefore, the present chapter explains the concept of 'social security' system in India and thereby highlighted the welfare measures which can prevent deprivation and vulnerability of senior citizens. In a nutshell, the chapter emphasized especially on the need and importance of social welfare programmes. It begins with the growth and development of social security measures in India and ends with the various government schemes. It also highlights the International initiatives for ageing like Madrid Plan of Action and Vienna Declaration. Moreover, the National Policy for Older Persons and five year plans werecovered to locate the position of senior citizens in the present context and

1 http://www.ehow.com

forecast the future directions of research. Thus chapter is an attempt to determine the policy implications for elderly in India.

2.01:The Concept of Social Security:

Social security system of any nation is meant for helping the people in needand at thetime of dependency including childhood, old-age, sickness, accident, unemployment, maternity, occupational risks, invalidity and retirement. The International Labour Organization[2] defines social security services as "one which provides the citizens with benefits designed to prevent or cure a disease or to support them during their inability to earn and to restore them to gainful activity". Thus the ultimate objective of any social security measure is to provide protection against contingency and also to the entire population of the country.Presently, the concept of social security has been extended from the notions of providing mere relief, compensation and pension to a wide range of services including social rights, standard minimum income, access to health and provision of basic services like housing, education etc.

Even though both, the developed and developing countries are providing social security system to its citizens but the developing countries are still lagging behind the developed ones. This is due to the resource constraints, low level of institutional development and relative powerlessness due to poverty of the developing nations.In addition, many key weaknesses in the direction of availability, adequacy and equity were observed in the existing welfare programmes of the developing nations like most of the administrative and implementation structures are expensive, poorly regulated and cumbersome; the requirement for trained and specialized personnel is given rare priority; there is a high level of non-compliance by both government and employers[3]etc.

Thus, in a situation like this, along with so much heterogeneity and diversity, it would be a real challenge for developing nations,including India, to meet the needs of its

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2 Rajan, S. I. (2000). *Financial and social security in Old age.*In Raju, S. S., Desai, M. (Eds.).Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p.118.

3 Davidson. K. (2001).*Reconstructing life after Death: Psychological adaption and social role transition in the medium and long term for the older widowed men and women in the U.K.*In Modi. I. (Ed.).Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.229.

senior citizens. Hence, there is an urgent need to analyze the problems of the aged with a different perspective[4].The primary task, therefore, of any ageing policy intervention should include recognition of the importance of the aged persons in human life, understanding of the process of ageing and the enhancement of the public recognition of the authority, wisdom, productiveness and other important contributions of older persons.

Needless to say, the future cohorts of older people are likely to be better educated, more urban, have smaller families and may utilized better health facilities, hence the older concept of ageing policy should need to be revised and re-evaluated. For re-evaluation;the essential is to look into the growth and changing patterns of social security measures meant for senior citizens in India and predict their future implications. Hence, in the next section the growth and development of social security measures in India has been discussed.

2.02: The Growth of Social Security Measures for Senior CitizensInIndia:

The concept of Social Security in India is not a recent phenomenon. It was observed from the Vedic period and even before. Historically, social security system for the development of aged in India can be classified into the following phases:

- Pre-Colonial Phase
- The Colonial Phase
- The Post-Independence Phase (Prior to 1980)
- The Developmental Phase(From 1980 onwards)

1. Pre-Colonial Phase:

The basic concept of social security for aged, as assistance and insurance, is not new in India. It begins with the ancient 'law-givers' of India and even before. The law givers of India always provided some social norms for coping with the subject of

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4 Bhawsar, R.D. (2001). *Population Ageing in India: Demographic and Health Dimensions*. In Modi, I. (Ed.). Ageing and Human Development: Global Perspectives. New Delhi: Rawat Publication. p.276.

ageing. For example, in about 2000 B.C., Manu, the first law giver spoke about the responsibilities of society towards the older people. Similarly, in the Post-Vedic period, Kautilya spoke about government's role in treating the elderly with respect and laid down various rules for the regulation of guilds, designed to provide collective security for life and prosperity of aged. Following the same, Shukracharya in his penetrating 'Sukraniti' have shown many a reference regarding sickness benefits, pension and old age benefits, family pension and maintenance allowances. In addition, a sort of "Moral Economy" existed to provide security to older destitute and other vulnerable groups in society. Even poor families without any productive assets were providing such security. Until recently, this traditional practice of supporting elderly formed the first choice for older generation. However, gradually, these traditional support systems are disappearing, and state-based social security systems have come into existence[5].

2. The Colonial Phase:

The Colonial Phase ranges from mid-eighteenth century to mid-twentieth century. During this phase, India was under the dictatorship of Britishers and the British government established various laws relating to security for all age groups. For old age security, they established separate funds to the formal employment sector such as Pension and Provident Funds and for destitute elderly a system of old-age homes was supported via grants. Four major pieces of legislations were also introduced, namely, The Pension Act, 1871; Worker's Compensation Act, 1923; Shariat Act, 1937 and the Indian Succession Act. The Pension Act was set up to provide a pension plan for colonial administrators that were made available to all government employees, including Indians in government employment. It was administered by Royal Commission on Civil Establishments. Amendments were also enacted by the Britishers in 1919 and 1935 and this was retained by the new Government of India, even after independence. Worker's Compensation Act was also enacted for government workers and was retained after independence. The act provides for the recovery of compensation amount by the elderly parents in case of death of a child during the course of employment. The other laws e.g. Shariat Act and the Indian

5 Kumar, S. V. (2003). *Economic, Health and Social Networks; Economic Security for the elderly: An Overview*. In Phoebe S. L.(Eds.).An aging in India: perspectives, prospects and Policies. New York. Haworth Press.p. 47.

Succession Act were enacted for both Hindus and Muslims and were based on the inheritance issues of the aged. The Adarker commission report was also given in 1944 to outline the foundation for an effective social security scheme based on the principles of administrative simplicity, flexibility, financial viability, expandability, and compulsory and contributory requirements[6].Hence, this phase was considered as the real beginner of state based initiatives or social security measures for elderly generation in India.

3. Post-Independence Phase:

After independence, the government was virtually concerned with its primary goal of maintaining law and order and was rapidly marched towards achieving the desirable goal of a 'welfare state' .The Adarker report of 1944, however, laid the groundwork for a social security system in India. India, being a federal government, put ageing on the concurrent list, that is, the government of India, as well as the state governments, can play and develop programmes for the elderly. In addition, Articles 42 and 47 of the constitution were introduced to deal with social security issues of the aged. Provisions were also made for working conditions, Provident Funds, Worker's Compensation, invalidity and old age pension. These provisions along with some other Constitutional safeguards were discussed as follows:

A. Constitutional safeguards for aged:

The following constitutional safeguards were accepted during this phase:

- **Article 41:** It states that"The state shall within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement and in other cases of underserved want". This article is not enforceable by the court as it was only given as a direction to States under directive principles.

- **Section 125(d)** of the Criminal Procedure Code (1973) makes it incumbent for a person having sufficient means to maintain his father or mother who is unable to

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6 Gokhale, S.D. (2003). *Towards a policy for Ageing in India.* In Phoebe, S. L. (Eds.).an aging in India: perspectives, prospects and Policies. New York: Haworth press. p.218.

maintain him/her and on getting proof of such neglect or refusal; a first class magistrate may order such person to make a monthly allowance not exceeding Rs.500. Thus it is based on the principle that it is the family which is responsible for their care. A recent court judgment has interpreted the provision to include daughters. Few people are perhaps aware of this position and fewer still get a court order for support, due probably to the sense of shame in seeking justice for what is viewed as essentially a family or private affair[7].

- **Item 9 of the State list** ; Seventh Schedule relates to the relief of the disabled and unemployable, the interpretation of which, as far as the subject of ageing is concerned, seems to be vague. It may mean providing relief to the physically handicapped and those who can't be employed, obviously because of physical limitations including, perhaps, of old age.

- **In the Concurrent list** of Seventh Schedule, three items can found to have a match with the ageing issues: Item 24has included in its preview among others, old age pensions. Item 23 mentions about social security and social insurance whereas, Item 20 is related to economic and social planning.

- The **Right to Equality** guaranteed by the constitution as a fundamental right is also applicable to the elder generation.

In addition to constitutional safeguards, the government also came up with certain legislative provisions to ensure a better quality of life for the aged. These safeguards are also discussed as follows:

B. Legislative Safeguards for Aged:

Legislative safeguards for aged includes the Employee's Provident Fund(EPF) Act and Miscellaneous Provision Act,1952[8] which aimed at making welfare provisions for the future of industrial workers after retirement and the benefits to their dependents, in case of early death. Further to keep the tradition of family economic solidarity, The

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7 Bose, A.B. (1988). *Policies and Programmes for the Ageing in India.*In Gangrade, K.D. and Bose, A.B. The Ageing in India: Problems and Potentialities.New Delhi: Abhinav Publications. p.60.

8 Prakash, I.J. (2007). *Maintenance and Welfare of Parents and Senior Citizens Bill, 2007: Some Reflections.* In Help Age India.Research and Development Journal.Vol.13. No.3. 2007.p.5.

Hindu Adoption and Maintenance Act, 1956 and The Hindu Succession Acts, 1956[9] were enacted. Section 20(3) of The Hindu Maintenance Act requires a person to maintain his/her aged or infirm parents for as long as the parent is unable to maintain himself out of his property or earnings.The Succession Act, on the other hand, is entitled to benefit, along with other beneficiaries, from the property of their deceased child.

Further, to bring relief to older persons without loss of time, the civil divisional office fixes the Amount and a Commissioner Act. Legislations including Income Tax Act, 1961 and The Payment of Gratuity Act, 1972 were also enacted for the older persons retired from any organized sector .The Income Tax Act provides for special tax benefits to elderly above the age of 65 years and The Payment of Gratuity Act,1972 provides an additional retirement benefit for industrial workers.

In addition to above initiates, various States have established a fixed amount as Old Age Pension for destitute elderly; U.P. was the first state to follow Old Age Pension scheme in 1957, followed by A.P. and Kerala. In 1971, Family Pension Programme was also started to help the families of industrial workers who die prematurely. Some States also started giving grants to voluntary organizations for the maintenance of destitute elders in Old Age Homes[10].

Hence, this phase is said to be the 'dawn' of the era of social security for aged as the state itself had taken the responsibility for ensuring a minimum standard of material welfare to all its senior citizens. No doubt, these safeguards introduced a modern concept of social security.Till the end of this phase i.e. by 1980s, it was generally accepted by the government that improvement in the conditions of health and wellbeing of the aged population is pre-essential for the economic growth of a nation. It is also needed for the overall development of a nation. Thus in the next phase i.e. the developmental phase, more concern has been shown towards the elder generation.

4. The Developmental Phase:

Developmental phase can be considered as the 'Golden-era' for the welfare of aged as it comprises of concentrated and continuous efforts towards the welfare of aged. By

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9 http://indianchristians.in/news/images/resources/pdf/hindu_succession_act_1956.pdf

10 Gokhale, S.D. (2003). *Towards a policy for Ageing in India.* In Phoebe, S. L. (Eds.).An aging in India: perspectives, prospects and Policies. New York: Haworth press. pp. 213-233.

late nineties, there were many factors including: population ageing, migration, urbanization, changing customs due to modernization, the changing roles of women due to employment and changes in the form of family; contributed for the development of a national policy for ageing. All these factors ripen the political situation and pressurized the political parties, to include ageing as a part of their main agenda .They also demand for a national policy .For government, this pressure became a cause for realization that not only did the destitute elderly need economic support and care, but a large portion of economically secure and fit aged also require emotional, psychological and community support. It therefore became a necessity for the government to introduce certain measures for the welfare of aged in all spheres and for all sections. Accordingly, government had initiated different measures in terms of five-year plans and other welfare schemes directed at making the lives of the elder more livable at national and international level. Few such initiatives were discussed as follows:

A. The First World Assembly on Ageing

The First World Assembly on Ageing was held in Vienna; Austria from 26thJuly to 6thAugust, 1982. As a result, India along with 123 nations adopted the United Nations First International Plan of Action on Ageing. The Plan of Action was adopted after 650 hours of discussion and concurrence from 2000 delegates from the world over. It was for the very first time in the history of the UNs, a plan of action was adopted unanimously without any hesitation from any country. The Assembly provided a forum for advocating for mainstreaming the interests of older persons in societies. It was expected that the Assembly should resulted in societies responding more fully to the socio-economic implications of the ageing of populations and the specific needs of older persons. The plan deals with both: the issues affecting the ageing as individuals and those relating to the ageing of the population. The Assembly not only solemnly reaffirmed the fundamental and inalienable rights enshrined in the Universal Declaration of Human Rights ,but also recognized the importance of Quality of Life and determined that the ageing, as far as possible, be enabled to enjoy in their own families and communities a life enriched with good health, economic security and contentment. The plan of action further emphasized the establishment of national

machineries to address the humanitarian and developmental needs of older people appropriate in each culture.

The primary objectives of holding this assembly were to strengthen the capacities of countries to dial effectively with the ageing of the populations and with the special needs and concerns of their elderly; and to promote an international response to the issues of ageing through action for establishment of new international co-operation, particularly among the developing countries. Accordingly, the Plan of Action set out some secondary objectives in consonance with the primary as: the promotion of national and international understanding of the humanitarian and developmental issues related to ageing, presentation of policy alternatives consistent with national goals and internationally recognized principles, development of appropriate education, training and research and the stimulation of action-oriented policies and programs for the elderly.

On recognizing the formulation and implementation of policies on ageing as a right and responsibility of State, the assembly made the following recommendations in various spheres:

i. **Health and Nutrition:**

- Health and Medical care should aim at alleviating the handicaps of ageing and also at infusing the spirit of self- confidence and self- reliance.
- The disabled and very old need to be given particular attention.
- Through proper health care and counselling, the elderly should be encouraged to lead independent lives in their own family and community, instead of getting cut-off from society.
- A proper diagnosis of nutritional requirements of the ageing should be an integral part of health care.
- Health services should include a broad range of ambulatory services, such as day care centre, out- patient clinics, day hospitals, medical and nursing care, and domestic services.
- Emphasis should be placed on lifelong health care rather than providing health care in old age only.

ii. Protection of Elderly Consumers:

- Government should ensure that food and household products, installations and equipment conform to standards of safety that take into account the vulnerability of aged.
- To encourage the safe use of medications, household chemicals and other products by requiring manufacturers to indicate necessary warnings and instructions for use.
- To facilitate the availability of medications, hearing aids, dentures, glasses and other prosthetics to the elderly so that they can prolong their activities and independence.
- To restrain the intensive promotion and other marketing techniques primarily aimed at exploiting the meager resources of the elderly.

iii. Housing and Environment:

- The availability of proper housing facilities for the aged has special psychological significance for them. National Housing Policies should pay due respect to the requirements of the ageing.
- The urban housing plans and human settlement policies should pay special attention to the specific requirements of the ageing.
- The housing should be made in an environment in which they can have the opportunity to lead a rich, normal and secure life.
- Efforts should be directed to law enforcement agencies and the elderly to increase their awareness of the extent and impact of crime against older persons.
- Whenever possible, the ageing should be involved in housing policies and programmes for the elderly population.

iv. Family:

- As the family is recognized as a fundamental unit of society, efforts should be made to support, protect and strengthen it in agreement with each society's system of cultural values.
- The governments should promote social policies encouraging the maintenance and strengthening of family solidarity among generations.
- Public opinion should be built up in favour of a system in which families are encouraged to take care of their elderly members.

- Within a family group, particular attention should be given to the special needs of the older women.
- The aged should be included in the decision-making process in the political, social, cultural and educational areas.

v. Social Welfare:

- Social Welfare services should be community-based and provide a broad range of preventive, remedial and developmental services for the ageing, to enable them to lead as independent life as possible in their own home and in their community, remaining active and useful citizens.
- Needs of ageing should be given due importance in drawing up plans and programmes for them. Cooperative organizations can play a useful role in this.
- Young people should be encouraged to involve themselves in providing social services for the aged as it would promote intergenerational ties.
- To encourage voluntary organizations, fiscal and other incentives should be given along with some relaxation in control and regulation.

vi. Income Security and Employment:

- The government should take appropriate action to ensure to all older persons an appropriate minimum income, and should develop their economies to benefit all the population.
- To create or develop social security schemes based on the principle of universal coverage for older people.
- Measures should be taken to assist older persons to find or return to independent employment by creating new employment possibilities and facilitating training.
- The right of older workers to employment should be based on ability to perform the work rather than chronological age.
- Measures should be taken to prevent industrial and agricultural accidents and occupational diseases.

vii. Education:

- Educational programmes featuring the elderly as the teachers and transmitters of knowledge, culture and spiritual values should be developed.

- Educational policies should reflect the principle of the right to education of the ageing, through the appropriate allocation of resources and in suitable education programmes.
- A coordinated effort by the mass media should be undertaken to highlight the positive aspect of the ageing process and of the ageing themselves.
- In accordance with the concept of lifelong education; community-based and recreation oriented program for ageing should be promoted in order to help them develop a sense of self- reliance and community responsibility.

Indian officials, through their participation in the World Assembly and by the adoption of the International Plan of Action recognized that the ageing will sooner become a cause of concern not only for the present society, but also for the future generations. The recommendations of the Plan assured for the consideration of the measures meant for the optimum utilization of wisdom and expertise of elderly. The plan helps in understanding the economic, social, cultural and political implications of ageing. It further envisaged the humanitarian and developmental issues, stimulation of action-oriented policies and the role of elderly in the overall process of development. The recognition of these aspects of ageing along with their problems and needs brings attention to the fact that the elderly need special concerns. Policy on ageing is the sovereign right and responsibility of each State, and would be carried out on the basis of its specific needs and objectives. Hence, based on these recommendations, the government of India came up with a bold initiative of introducing National Policy on Ageing[11].

B. The National Policy for Older Persons, 1999:

The Demographic Transition from a mature society to an ageing society resulted in the formulation and adoption of the NPOP by the Government of India. In January'1999 the government came up with the National Policy on Ageing. The policy document is a comprehensive document which provides a background of the demographic trend to the ageing population with implications at the macro and micro

11 Saxena, D.N. (1988). *Senior Citizens: Their problems and potentialities.* In Gangrade K.D and Bose A,B. The Ageing in India: Problems and Potentialities. New Delhi: Abhinav Publications. pp. 92-96.

level[12].The basic goal of the policy is to strengthen the legitimate place of older persons in society and help them live their last years with purpose, dignity and peace. The policy strives to encourage families to take care of their older family members. It provides broader framework for inter-sectoral collaboration and cooperation both within the government as well as between government and non-governmental agencies. In particular, the policy has identified a number of areas of concerns for the well-being of elderly which are discussed as follows:-

i. Financial Security:

In NPOP, financial security is considered as one of the major areas of intervention for different income groups. It assures financial assistance to all older persons living Below Poverty Line under the Old Age Pension Scheme. It also includes revision of monthly pension at regular intervals; establishment of Pension scheme at public and private sector with provision for employers to contribute inflation effects; administrative issues of the old age pension; better returns from the Provident Fund; the expansion of pension; tax relief for co-resident families with elders etc. Promotion of income generating activities after retirement, the promotion of long term saving instruments, and the rights of elders to be supported by their children are also reported as the part of their financial security.

ii. Health Care and Nutrition:

The NPOP is strongly committed to prioritize the health needs of the elderly, with an emphasis on long term management of illness at home. Elders' health care needs are on high priority, with a goal of good affordable health services, heavily subsidized for the poor and a graded system of user fees for others. A mix of public health services and insurance, combined with not-for-profit and private health care services, is envisioned. It suggested for the strengthening of the primary health units, Provision of Geriatric facilities at secondary and tertiary levels, with special counters for elders at public hospitals and specialized geriatric training for medical and paramedical personnel. NGOs were expected to come out as a major role player in providing mobile health services; special health camps; hospice care and counselling and information services to families on the care and treatment of elders with mental health problems. Besides, promotion of self-care, family care, nutritional needs, effective

12 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal; Statistics Speak.* New Delhi: B.R Publishing Corporation. p. 161.

ways of healthy ageing, the strengthening of health education programmes by using mass media were found to be the other areas of intervention for the aged.

iii. Shelter:

A third major emphasis is on elder housing. It was recommended that ten percent of the allotments by major housing schemes of both rural and urban areas will be earmarked for the elderly with provision to give them preference in allotment of the ground floor. Moreover, elders will be given easy access to housing purchase and repair loans; housing developments will be expected to be responsive to their community based amenity needs, including multipurpose senior centers; and information concerning accident prevention will be provided to elders and their families. Group housing of older persons, with common service facilities, will be encouraged, but age segregated housing that prevents interaction with rest of the community is to be avoided. The policy recommended institutional care in old age homes as the last resort.

iv. Education:

Information and education material relevant to the lives of older persons was considered useful by the NPOP. It was suggested that such materials be widely disseminated; curricula at all levels will incorporate materials to strengthen intergenerational bonds; schools will develop outreach programmes to interact with seniors on a regular basis; and contributions of the elderly will be highlighted by the media.

v. Welfare:

For providing welfare services to the aged, it becomes necessary to identify the more vulnerable group among the elderly cohorts, e.g., disabled, infirm, chronically ill, widows and those who are living alone. Policy promotes those welfare programmes and institutional services which strengthen the capacities of the aged and their families. Policy also suggests the older people to form informal neighborhoods to satisfy their social and recreational needs. A welfare fund for elders will also be created, with tax-deductible funding from corporations, trusts, charities, and individuals combined with government funds. States will also establish similar funds.

vi. Protection of Life and Property:

Protective services against fraudulent dealings and physical and emotional abuse, especially of widows, will be provided, with NGOs playing major roles. Police will

keep a friendly eye on older couples and individuals living alone. Elders will also get free advice on maintaining effective relationships with the family and ways of taking precautions against the crime. The policy document pointed out the need to provide and strengthen the necessary provisions in the Indian Penal Code against elder abuse. It seeks to strengthen the section 125 of the Criminal Procedure Code.

vii. Family and Familial support:

The NPOP regards families as the main care providers with suggestions in the policy document to sensitize the younger generation towards their role in inter-generational bonding. It envisages a change in the mindset of people with recognition to the useful role of women in the household and married daughter in coping and supporting her older parents, particularly when there is dearth of caregivers from the family. It encourages traditional co-residence via tax-relief, medical expense rebates and housing preference.

viii. Affirmative Action:

Other interventions involve affirmative actions on behalf of elders. These include concessions and facilities for travel by Indian Railways, Indian Airlines and State Transport Corporations, preferential seating and easy access to services, speedy disposal of elders' complaints and featuring issues relevant to elders. Moreover, a list of Central and State government programmes for elders will be compiled, updated regularly and disseminated widely to associations of older persons.

ix. Voluntary Sector:

The primary mechanism described in the NPOP is the grant-in-aid scheme. Policy envisages special assistance to trusts, charities and other endowments to expand activities and services for the elderly. Moreover, the promotion of NGO networking, information exchange and training of NGO personnel are also used as a strategy.

x. Research on Ageing and its ramifications:

Emphasis was also placed on research in socio-medical gerontology and the required database. Policy promotes research and training by setting up of regional centers for Geriatric and Gerontological studies, providing research grants, creating a national institute and an interdisciplinary coordinating body on research, and strengthening professional associations in ageing. Manpower training will focus on geriatric specializations in medical colleges, training institutes for nurses, and in-service training centers. Curriculum development assistance, especially in Schools of Social Work and other University departments, and training of NGO personnel are seen as

vital approaches, as is sensitivity training for persons in the legislative, judicial and executive branches of government at all levels. Finally, the media was recognized as an important player in highlighting the changing situation of elders and in identifying issues and areas of action[13].

Thus by looking into the above areas, it could be said that NPOP is a comprehensive document covering almost all spheres of life. But to know the effectiveness of this policy document; it is required to check its implementation in terms of welfare schemes.

Implementation of NPOP:

The Ministry of Social Justice and Empowerment is the leading agency to co-ordinate all matters relating to the implementation of NPOP, via a new and separate Bureau of Older Persons and the participation of different national departments of the Government through an Inter-Ministerial committee.Some of the steps taken by the Ministry in the direction of the implementation of NPOP include:

- The National Planning Commission and Finance Ministry will facilitate budgetary provisions required for implementation.
- States are encouraged to set up separate Directorates/Departments of older persons for coordination and monitoring at the state level.
- At the village level, PRIs will be encouraged to participate in NPOP implementation by addressing local level issues and needs of the elderly and developing programmes for them, and by providing forums, which ensure adequate representation of older women, to discuss elders' concerns and actions to be taken. Further the PRIs will be assisted for providing institutional and non-institutional services to older persons.
- Instructing each national Ministry to prepare Five-Year Plans and Annual Action Plans about their implementation of aspects of the NPOP that fall into their jurisdiction. Each Ministry's annual report will indicate the progress achieved during the year.
- Constitution of an Advisory Council to provide advice to Ministry by reviewing the policy from time to time and providing expert advice to the Minister. It is an

13 Ibid, pp. 162-164.

expert group that can link the government with NGO activity through discussion and networking.

- Every three years a detailed review document will be prepared on the implementation of the NPOP.
- Health care being provided to the older persons through Bhavishya Arogya Mediclaim and Rural Group Life Insurance Schemes.
- Constitution of two new autonomous entities naming NCOP and NOAP; to promote and coordinate in the concerns of older persons.
- Launch of an Old Age Social and Income Security project(OASIS), which comprehensively examined policy questions connected with the income security of the aged[14].

To put these initiatives in action, the Ministry for Social Justice and Empowerment set up an autonomous body named as National Council for Older Persons whose functions are discussed as follows:

C. National Council for Older Persons:

NCOP was started under the chairmanship of Mrs. Maneka Gandhi. The council constitutes 39 members including representatives of relevant Central Ministries and the Planning Commission. A seven member working group has also been constituted from amongst the members of NCOP. Adequate representation will be given to non-official members representing NGOs, academic bodies, media and experts on ageing issues from different fields. Moreover, five States will be represented on the Council by rotation. The basic objectives of the NCOP are:

- To advice the government on policies and programmes for older persons.
- To identify the role of various Ministries for the implementation of NPOP.
- To provide feedback to the government on the implementation of NPOP and set an Inter-Ministerial committee for coordination.
- To facilitate setting up of a National Association of Older Persons.
- Senior Citizens Welfare Fund will be set up at the Centre.
- PRIs will be assisted for providing institutional and non-institutional services to older persons.

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14 Gokhale, S.D. (2003). *Towards a policy for Ageing in India.* In Phoebe, S. L. (Eds.).An aging in India: perspectives, prospects and policies. New York: Haworth press. pp. 213-233.

- To provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature.
- To provide lobby for concessions, rebates and discounts for older persons both with the government as well as with the corporate sector.
- To suggest measures to enhance the quality of intergenerational relationships.
- Training and orientation of workers and volunteers in organizations providing services to the elderly will be facilitated.
- Instruments, which provide for old age social and income security for unorganized sector workers as recommended by OASIS committee, will be developed.
- Promotion of research on ageing issues. Professional Association of Gerontologists to be encouraged to strength research activity, disseminate research findings and provide a platform for dialogue.
- Special provisions to be made for relief and rehabilitation of older persons in the existing relief code.
- Extending assistance to organizations to provide career guidance, training, placement and support services to older persons[15].

In addition to establishing NCOP, government had taken the following initiatives to make the ageing policy worthwhile and task-oriented:

D. AADHAR:

The Ministry of Social Justice and Empowerment has commissioned AADHAR in December1999, to make it a part of the secretariat of NCOP and to provide legal, medical and social assistance to older people across the nation. AADHAR is an initiative in the direction of empowering the elderly population of India and to find satisfactory solutions to the problems of aged. This could be achieved through the coordination of voluntary efforts and administrative initiatives. Since its inception, AADHAR has been attending to requests for intervention from all over the country, by the Ministry and various other government agencies and functionaries. Presently based in Delhi, it is being coordinated by Age well Foundation. It is also coordinating district level support for local solutions and assistance for problems being faced by elder people. It is also identifying committed individuals and organizations across the

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15 Chakroborthy, R. (2004). *The Greying of India: Population Ageing in the context of Asia.* New Delhi: Sage Publication. p.360.

country right up to the district level, which would assist in implementing a grass root level action program. It is aimed at developing a network of socially committed individuals in every single district to provide local level assistance to older persons. In addition to regular activities, AADHAR has initiated a process of identification for setting up voluntary action groups in all the districts of the country for better implementation of ideas and to provide for older persons effectively at the local level. Besides, volunteers are being provided with study material and training to look after the needs of older persons locally[16].

E. National Association of Older Persons (NAOPS):

Another autonomous body named as National Association of Older Personssimilar to the U.S. Federal Council on Ageing was established under NPOP to mobilize senior citizens, articulate their interests, and to promote and undertake programs for their well-being. It also advises the government on all matters relating to the older persons. The Association will have National, State and District level offices and will choose its own office bearers. The government is responsible for providing financial support to establish the National and State level offices while the District level offices will be established by the Association from its own resources which may be raised through membership subscriptions, donations, and other admissible means. The government will also provide financial assistance to the National and State level offices to cover recurring as well as non- recurring administrative costs for a period of fifteen years only and thereafter the association is expected to be financially self-sufficient. District offices will be funded by the NOAPS from its resources raised from a variety of means including dues and donations[17].

F. Benefits Given to Senior Citizens by Different Ministriesand Government Departments:

In consonance with the guidelines given in NPOP, various government department and Ministrieshave set their own guidelines and started plenty of programs for the welfare of senior citizens. These programs along with their guidelines are given as follows:

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16 Bose, A. and Kapur, M. (2004). *Growing old in India: Voices Reveal; Statistics Speak.* New Delhi: B.R Publishing Corporation. p.166.

17 Ibid, p.213.

I. Ministry of Social Justice and Empowerment:

- The Ministry of Social Justice and Empowerment is the Nodal Ministry responsible for the welfare of senior citizens.
- The Ministry has announced the National Policy on Older Persons.
- The Ministry has written to all the Ministries/State governments concerned for adopting a uniform age of 60 years for conferring the status of senior citizen to a person and for extending facilities/concessions to them.
- The Ministry requested State governments to issue a multi-purpose identity card to senior citizens.
- The Ministry is implementing various schemes for the benefit of senior citizens as:(a)The Scheme of assistance to PRIs/ Voluntary Organizations / SHGs for construction of Old Age Homes or Multi-service centers for older persons. Under this scheme, one time grant is provided. (b) An Integrated Program for older persons. Under this scheme, financial assistance up to 90 percent of the project cost is provided to NGOs.

II. Ministry of Health and Family Welfare:

- The Ministry has issued instructions to all State Governments to provide for separate queues for older persons in hospitals for registration and clinical examination.
- Affordable health services will be made available to older persons, heavily subsidized for the poor and a graded system of user charges for others.
- The health Insurance sector will be given relief and concessions to enlarge the base of coverage and make the schemes affordable.
- The primary health care system will be strengthening to meet effectively the health care needs of older persons.
- Trusts, Charitable societies and Voluntary agencies providing health care to older persons will be promoted , encouraged and assisted by way of grants, relief, land at subsidized rates and other concessions.
- Facilities for testing and treating visual impairment, hearing impaired, dental and locomotion problems will be expanded considerably.

- Treatment facilities for chronic, terminal and degenerative diseases will be expanded
- Public hospitals will be directed to provide separate O.P.D. counters for older persons
- Medical Social Workers in hospitals will be given the right orientation on how to care for elderly patients in hospitals.
- The setting up of Welfare Funds to provide for free treatment and medicines to the poor elderly patients will be facilitated.
- Geriatric wards will be provided in the hospitals.
- Hospices will be set up to cater to the needs of the chronically and terminally ill, aged patients.
- Mobile health services will be organized to reach out to the elderly, particularly women, the poor and the infirm in rural and urban areas.
- Medical college will be assisted to provide facilities for specialization in geriatric medicine.
- Medical and paramedical personnel will be given training and orientation on morbidity patterns of the elderly and their treatment and rehabilitation.
- The concept of healthy ageing will be vigorously promoted. The preparation and dissemination of educational material on healthy ageing will be assisted.
- The medical fraternity will be encouraged to set up geriatric care societies at the National, State and District level.
- Associations of older persons and retired medical professionals will be encouraged to organize mobile health awareness and health check-ups.

III. Ministry of Finance:

- Separate counters are marked for senior citizens at the time of filling the Income Tax Returns. Spot assessment facility is also provided.
- R.B.I. has higher rates of interest on saving schemes of senior citizens (65 and above). Accordingly, w.e.f.15th May, 2001, banks permitted 0.5 percent higher rates of interest on fixed deposits.
- For senior citizens, the deduction in respect of medical insurance premium is up to Rs.15, 000 under section 80D of Finance Act.

- Section 88 of the Finance Act provides income tax rebates of up to Rs. 15000 or actual tax whichever is less to senior citizens who have attained the age of 65 years.
- Senior citizens are excluded from "one by six" scheme for filling the income tax return under section 139(1) of the Finance Act.
- Pension schemes will be devised to reach out to self-employed and other persons currently not covered by pension.
- The insurance, mutual funds and banking sector will be encouraged to play a big role in promoting long-term savings for old age.
- Taxation policies will take cognizance of heavy liabilities on older persons to meet their survival, health and other needs during old age.
- The proposed Welfare Fund for senior citizens will be provided tax relief.

IV. Ministry of Rural Development and Employment:

- Ministry has launched National Old Age Pension Scheme and Annapurna schemes for the aged.
- The non-contributory pension schemes for older persons will be progressively expanded to reach all elderly persons living BPL.
- The system of disbursement of pensions will be streamlined and a strict watch kept preventing delays and abuses.
- Providing old persons, living BPL, a fixed quantum of food grains at a heavily subsidized rate or free of cost.
- Poverty alleviation schemes of the Ministry will show sensitivity to older persons.
- Public rural housing schemes for older persons will include subsidized housing programs.

V. Ministry of Urban Affairs and Employment:

- The Ministry will help remove physical barriers to mobility and provide easy and safe accessibility to public places.
- Town planners and architects will be sensitized to the needs of older persons for a comfortable and safe home, neighborhood and city.

- Guidelines will be developed for the design and construction of old age homes and day care centers to make them lively places.
- In multi-storied housing without elevators, preference will be given to older persons in the allotment of flats on the ground floor.
- Older persons will be given easy access to loans with easy repayment schedules.
- Roads, footpaths, and street crossings will be modified to ensure safe movements of older persons.
- Every housing colony will be required to have a multi-purpose centre for older persons.
- Flats for older persons with common service facilities for meals, laundry, common rooms, rest rooms and guest rooms will be encouraged.
- Norms will be laid down to check noise and other forms of pollution.
- Older persons will be given special consideration over matters relating to transfer of property, property tax and others.
- State governments will be requested to earmark and allot lands at concessional rates to trusts, charities etc. for the construction of old age homes.

VI. Ministry of Information and Broadcasting:

- Ministry will identify the issues related to elderly, developed programmes and allocated time for their broadcast.
- Ministry will promote the concept of active ageing.
- Interaction between media and persons active in the field of ageing will be facilitated.
- Programs will target older persons in order to help them enrich and update their own knowledge, and also pass on more effectively the socio-cultural heritage to their grandchildren.
- Organizations concerned about ageing issues will be requested to institute awards for the best reporting on ageing in print, radio and television in English and the regional languages.

VI.Ministry of Communications:

- Telephone connection is given priority to senior citizens of age 65 and above by the Ministry of Telecommunications.

- Immediate action will be taken in the matter of transfer of telephones and redressal of faults.
- Telephone advisory bodies will include a nominee from the NPOP.
- Telephone tariff concessions in the case of domestic use will be considered.
- Postal authorities will issue, every year, on the National Day for Older Persons a commemorative postage stamp.
- Messages relating to older persons will be printed on inland letters, aerogramme, and other items of postal stationery.

VII. Ministry of Railways:

- Indian railways provide concession in all classes and trains including Rajdhani/ Shatabdi trains for both males and females aged 60 years and above.
- The railway authorities will provide better services to senior citizens at booking counters, railway platforms and waiting rooms during the journey.
- Allotment of lower births, availability of wheel chairs and easy access to retiring rooms will be ensured for older persons.
- Senior citizens will be provided protection from harassment by coolies and anti-social elements.
- A senior officer will be nominated by the railways for speedy redressal of the grievances of older persons.

VIII. Ministry of Civil Aviation:

- The airlines will consider the facilities they can provide to senior citizens to make their travel comfortable.
- The airlines will provide wheel chairs and easy access to waiting rooms for disabled and very old.
- Indian airlines/Jet Airways is providing 50 percent discount on basic fare for all domestic flights in Economic class to senior citizens having the age of 65 years for both males and females.

IX. Ministry of Road Transport and Highways:

- State road transport authorities will consider giving fare concessions to senior citizens.

- Buses will be designed in such a way so as to provide easy entrance and exit, and safely to the elderly.
- Reservation of two seats for senior citizens in front row of the buses of the State Road Transport Undertakings.

X: Ministry of Petroleum and Natural Gas:

- Senior citizens will be given high priority in the allotment of gas connections for domestic use.
- Complaints of senior citizens will be attended on a priority basis.

XI: Ministry of HRD:

- The Public Distribution System will reach out to cover all older persons below the poverty line and issue ration cards promptly.
- Open Universities/ departments of continuing education of Universities will be encouraged to develop and offer continuing education packages relevant and useful for older persons.
- The curriculum at different stages of education will include course material on older persons to encourage values of caring towards the old.
- The departments of social sciences in Universities will be requested to include courses on ageing in their curriculum and encourage students to take up research on ageing at the M.Phil and Ph.D. level.
- Corporate bodies, banks, trusts and foundations will be approached to set up centers devoted to the study of ageing.
- Libraries of Universities, research institutions and others academic and cultural bodies will be requested to permit older persons to utilize their facilities.
- Interactive programmes b/w associations of older persons and schools will be promoted.

XII: Ministry of Home Affairs:

- Police departments will be directed to pay special attention to the security of life and property of older persons.

- Information will be provided to senior citizens and residents Welfare Associations on the precautions necessary to ensure the safety of the elderly in the neighbourhoods.
- More stress will be given on maintaining close contacts with friends and neighbours and sharing information on security matters.
- The National Crime Record Bureau (NCRB) will compile and publish in its annual publications the data regarding the crime and abuse against the elderly.
- The Registrar General and Census Commissioner will include questions on older persons in the decennial census operations.

XIII: Ministry of Law, Justice and Company Affairs:

- The Honorable Chief Justice of India has advised Chief Justices of all High Courts in the country to accord priority to cases involving older persons and ensures their expeditious disposal.
- Legal advice and helpline services will be provided to older persons to protect them from abuse, fraud and coercion in connection with property rights.
- Legal aid services to older persons will be expanded.
- State legislation will be modified so that older parents unable to maintain themselves do not face abandonment and acute neglect.
- Steps will be taken to simplify the adequacy of current provisions granting rights to parents with no support from their children and provide speedy relief in such cases.

XIV: Ministry of Labour:

- The National Commission on labour will be requested to give its recommendations on older workers.
- The National Labour Institute will include older workers in its programme of activities.
- Trade unions will be encouraged to promote the cause of older workers.
- Organizations will be assisted to provide career guidance, training, placement, and support services to older persons.

- Pre-retirement counseling programmes will be promoted and assisted.
- Coverage of establishments in which workers are entitled to contributory Provident Fund, Pension and other retirement benefits will be progressively increased.

XV:Ministry of Science and Technology:

- Research on ageing will be recognized as a priority area and funds will be allocated for supporting research.
- Development of aids and appliances for use by older persons will be encouraged.

XVI:Ministry of Planning:

- The planning Commission will sanction outlays for schemes on older persons.
- The National Sample Survey Organization will be generating data on older persons.
- Special Surveys on older persons will be conducted at periodic intervals[18].

G. National Schemes for the Welfare of Senior Citizens:

Based on the above guidelines the various Ministries have started the following programmesfor the welfare of senior citizens:

- **National Old Age Pension Scheme (NOAP):**

NOAP scheme was initiated by the congress government in 1995 and provides for a pension of Rs.75/- per month to the old people living in the constitutions of destitution. The scheme was started all over India and benefitted the most vulnerable sections of Indian society like women and lower caste individuals[19]. Under this scheme central assistance is given only after fulfilling the following criteria:

a. The age of the applicant (male or female) should be 65 years or more.

b.The applicant must be a destitute in the sense that he/she has no regular means ofsubsistence from his/her own source of income or through financial support from family members or other sources[20].

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18 Chakroborthy, R. (2004). *The Greying of India: Population Ageing in the context of Asia.* New Delhi: Sage Publication. pp.362-370.

19 www.india.gov.in.

20 www.karmayog.org

The scheme is a response to the deprivation and insecurities faced by our elderly. Therefore, it has certainly proved to be beneficial and worthwhile. The scheme fulfills an important commitment of government providing a social safety net for the poor and vulnerable. The scheme is implemented in the State and Union Territories through Panchayats and Municipalities. Both Panchayats and Municipalities are encouraged to involve voluntary agencies as much as possible in benefiting the destitute elderly for whom this scheme is intended. The State governments have been directed to ensure that the pensions are paid regularly i.e. before seventh day of each month. With every year the government is increasing the budgetary allocation for the scheme as it was Rs.450 crores in 1999 and was increased to Rs.465 crores in 2002. The numbers of beneficiaries were also increasing. But over a period of time, few gaps were noticed in NPOP like the amount of Pension being provided was very low. Besides it was covering only destitute. Hence, as a first step, a new scheme was launched on 19th Nov' 2007 as the "Indira Gandhi Old Age Pension Scheme". The scheme is a demand driven social security programme and is not restricted by budgetary allocations. Under this scheme the Central Assistance was revised from the meager Rs.75 per month to a more substantial Rs.200 per month. States have also been asked to match this raise and will provide Rs.400 per month as an individual pension. The Old Age Pension covers all senior citizens of age 65 and above in all BPL Families. The pension will be credited, wherever possible, into a post-office or bank account of the beneficiary.[21]

- **Annapurna Scheme:**

The Central government announced in the year 1999 another social security programme called 'Annapurna' for the destitute elderly and has been launched with effect from 1st April' 2000. It aims at providing food security to meet the requirement of those senior citizens who, though eligible, have remained uncovered under the National Old Age Pension Scheme (NOAPS). The Scheme is targeted to cover, 20% (13.762 Lakh) of persons eligible to receive pension under NOAPS. It is an 'In kind assistance scheme' which provides all older persons, eligible for the NOAPS; a 10 Kg. of rice or wheat per month. It is provided free of cost through the existing public distribution system (PDS). In its maiden appearance, the programme supported 0.66

21 www.newshopper.sulekha.com

million people[22].The Central assistance under the Annapurna Scheme is, thus, provided to the beneficiaries on fulfilling the following criteria:

- ✓ The age of the applicant (male or female) should be 65 years or above.
- ✓ The applicant must be a destitute in the sense of having little or no regular means of substance from his/her own source of income or through financial support from family members or other sources. In order to determine destitution, the criteria, if any, in force in the States/UTs may also be followed.
- ✓ The applicant should not be in receipt of pension under the NOAPS or State Pension Scheme.

For implementation of this scheme, funds have been released to the State Departments of Food and Civil Supplies in one installment. This Department then ties up with the Food Corporation of India (FCI), to release food grains district wise on payment of the cost of Food grains at CIP rates directly to the FCI offices. Initially, the food grains were supplied at economic cost (Rs.9.80 per Kg.). However, w.e.f. 1.11.2000, food grains are supplied at the CIP rates for BPL families (Rs.4.90 per Kg.) The beneficiaries under the scheme are selected in the Gram Sabhas and the Gram Panchayat distributes the entitlement cards to the beneficiaries.

- **Project OASIS:**

To enhance financial security of older persons in the country the government commissioned a national project called "Old Age Social and Income Security"(OASIS), devised for setting up a pension system for its citizens.The government realizes that poverty alleviation programmes directed at the aged alone cannot provide a complete solution to the problem. Faced with such large numbers, it is apparent that the problem will have to be addressed through self-help where people prepares for old age by savings. The role that the government can play in this enterprise is to create an institutional infrastructure to enable and encourage each citizen to undertake this task. Project OASIS, the first comprehensive examination of policy questions connected with old age income security, took birth in this background.

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22 www.india.gov.in

The basic mandate of the project is to make concrete recommendations for actions which the GoI can take, so that every young person can genuinely build up a stock of wealth through his/her working life,which would serve as a shield against poverty in old age. The need for this arose because of lack of adequate instrument to enable workers in the unorganized sector to provide for their future old age[23].It was estimated that barely 34 million of the working population is eligible to participate in formal provisions meant to provide old age income security. On the other hand, approximately 268 million workers in the unorganized sector are excluded from participating in the existing provisions. Therefore, almost 90 percent of India's work force remains uncovered under any social security means. The recommendations of the project are expected to benefit this target population. An eight member expert committee was mandated under the chairmanship of Dr. S. A. Dave; to examine policy questions connected with old and to make concrete recommendations for actions for enhancing social security. The final report of the project was submitted to the Prime Minister on fourteenth Jan, 2001 by the Minister of State for Social Justice and Empowerment. The Social Defence Bureau is taking the necessary action for the implementation of the recommendations of the report[24].

Recommendations under project OASIS

The research and recommendations under project OASIS have been segregated into two phases:

The first phase will cover existing mechanisms for social security-Employee Provident Fund, Pension Schemes and Public Provident Funds, the Annuity Plans of L.I.C, U.T.I, etc. It has provisions for long life economic security during old age to their members and better realizes their full, intended potential by removing systemic distortions and discriminations. It also recommends for the formation of a National Senior Citizen's Fund. The recommendations of the committee are being examined by the Ministry of Finance for further action.

The second phase will focus on research and recommendations for non-contributory government pensions, occupational and private pension plans; individual choice of

23 www.india.gov.in
24 Ibid.

diverse funds and fund managers, Regulatory Authority for the Pension Fund industry, a new and fully funded contributory pension provision for the balance(uncovered) workers including casual workers, self-employed , farmers etc., consolidation and strengthening of the existing publicly funded social welfare schemes like the NSAP, the pension and gratuity schemes of the central government[25].The recommendations further shows that regular savings between Rupees three to five per day through the entire working life easily suffices for survival in old age, provided the pension assets are invested widely. The project also recommends that the new system devised for pension system in the country would be based on Individual Retirement Accounts(IRA). The IRA account number of an individual is a unique number. The individual would save and accumulate assets into this account during his working period. The account would stay with the individual through a change of job, spell of unemployment, and can be accessed at any location in India. The minimum one time contribution will be Rs.100 and total accretion will be Rs.500 per annum. Finally, upon retirement, the individual would be able to use his pension assets to buy annuities from annuity providers and obtain a monthly pension. The government for the implementation of the above mentioned Pension Systems has envisaged a role of NGOs, which can play a key role in education and advocacy. They can assist in obtaining the transition of millions of individuals into the Pension Systems. Further, NGOs can play an important role in obtaining steady contributions to the pension fund; and imparting knowledge in connection with the various choices that individuals in the pension system face[26].

Thus the recommendations of OASIS, which form the basis of any future of policies of the government on savings, have a twin focus of further improving the existing pension provisions and to devise a fresh pension plan for excluded workers.

- **Scheme of Assistance to PRIs/VOs/SHGs for construction of Old Age Homes/ Multi-Services Centre for older persons:**

Under the auspices of the NPOP; the government has implemented a scheme of assistance to PRIs and Voluntary Organizations / SHGs, which are working as

25 www.kamayog.org

26 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal; Statistics Speak.* New Delhi: B.R Publishing Corporation. p. 168.

registered societies, public trusts, or charitable companies for the construction of old age homes/multi-service centers for older persons. The assistance is forthcoming from the centre facilitated for the purpose only to those who submit their applications in the prescribed Performa to the Ministry and who produce a clear title of land on which the centre is proposed to be constructed. Assistance is also granted for expansion of the existing building of multi-services centre/old age homes by grant of funds in easy installments. As part of the scheme to assist programmes for older persons, grant is also provided to eligible persons for running old age homes, day care centers, Mobile Medicare Units, and also non-institutional services. The grant is sanctioned based upon the assessment made by a prescribed agency of the Ministry. The aim of the applicant has to be to improve the quality of life of older persons and those eligible for assistance are bodies like autonomous government institutions, local bodies and cooperative societies registered under an appropriate act[27].The scheme was revised during 1998-1999 to enhance the one time construction grant for old age homes/multi service centres from Rupees Five lakhs to thirty lakhs to eligible organizations[28].

- **An Integrated Programme for Older Persons**:

This has been formulated by revising the earlier scheme of 'assistance to voluntary organizations' for programmes relating to the welfare of the aged during 1998-1999 with an aim to empower and improve the quality of life of older persons, the programmes hopes to: Reinforce and strengthen the ability and commitment of the family to provide care to older persons; Foster amiable multi-generational relationships; Generate greater awareness on issues pertaining to older persons and enhanced measures to address these issues; Facilitate productive ageing; Popularize the concept of lifelong preparation for old age at the individual and societal level; Strengthen capabilities on issues pertaining to older persons of local bodies / State governments/ NGOs and academic and other institutions. The scheme provides for a financial assistance up to ninety percent of the project cost is provided to NGOs for establishments and maintaining old age homes, day care centre, mobile Medicare units and for providing non institutional services to older persons[29].

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27 Ibid, p.169.
28 www.karmayog.org
29 Ibid.

H. Benefits to Senior Citizens Working in Organized Sector:

Welfare of senior citizens working under the organize sector was always an area of concern for the authorities. The government is providing following facilities and benefits to the retired aged:

- **Pension Benefit:**

People who retired from service between 1st January' 1996 to 2004 are eligible for receiving pension amount at the rate of 50 percent of their basic pay. Pension for people who retired before 1st January 1996 will be fixed based on 50 percent of the minimum of the new scale applicable in place of old scale, in which they retire. A special provision has been made for people who retire before completing 10 months of service after 1st January' 1999, i.e., before 30th september1996 and have opted to come over the revised scales of pay. They are eligible to weight age at 40 percent on the existing basic pay for arriving at average pay fixation of pension[30].Most of the non-industrial staff in various government departments other than the Indian Railways are providing pension to their employees under this scheme. The maximum period of service for getting full pension is 33 years. Government employees who retire after 33 years of service are entitled to monthly pension at rates ranging from 43 percent to 50 percent of their "emoluments". Employees with less than 33 years of service are entitled to pension in the same proportion to the years of service[31].

- **Family Benefits:** following benefits have been provided to the family of the employee in case of his/her death during the service:

✓ Family Pension is provided to the dependent surviving member of the family, if, the member of the scheme dies during his/her service before attaining the age of 60 years.
✓ Death- cum- retirement gratuity.
✓ Balance of Provident Fund.
✓ Leave encashment up to 180 days.

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30 Chakroborthy, R.(2004). *The Greying of India: Population Ageing in the context of Asia.* New Delhi: Sage Publication. p.375.

31 Raju, S. S. (2000). *Ageing in India: An Overview* .In Raju, S. S., Desai, M. (Eds.).Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p. 131.

- ✓ Funeral expenses.
- ✓ Children Education Allowance and Tuition Fees reimbursement[32].

- **Dearness Relief:**

The grant of Dearness Relief is provided to central government pensioners/family pensioners who had drawn a lump sum payment on absorption in a PSU/autonomous body and have become entitled to restoration of one-third commuted portion of pension as well as revision of the restored amount in terms of this department's OM No. 4/59/97-P and PW dated 14 July 1998, as applicable to serving employees on the restored amount of one-third commuted portion of pension w.e.f. 1 Jan 1999. Hence, the following categories of Contributory Provident Fund (CPF) beneficiaries who are in receipt of Dearness Relief are:

- ✓ The widows and dependent children of the deceased CPF beneficiary who had retired from service or died while in service prior to 1.01.1986 and are in receipt of ex-gratiapayment of Rs. 605 per month.

- ✓ The Central Government employees who had retired on CPF benefits before 18.11.1960 and are in receipt of ex-gratia payment of Rs.654, Rs.703 and Rs.695.

- ✓ The Central Government employees who had retired on CPF benefits between 18.11.1960 to 1.12.1985 and are in receipt of ex-gratia payment of Rs.600 w. e. f. 1.11.97[33].

- **Gratuity:**

The provision of gratuity was made for government employees under thePayment of Gratuity Act, 1972 with an eligibility of having a minimum of 5 years of qualifying service. This is a one-time lump sum benefit calculated at the rate of one-fourth of the month's basic pay plus the DA last drawn before retirement for each completed six-monthly period of qualifying service. There is no minimum limit for the amount of

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32 Rajan,I. (2000). *Financial and Social Security in old age.*In Raju, S. S., Desai, M. (Eds.).Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p.137.

33 Chakroborthy, R. (2004). *The Greying of India: Population ageing in the context of Asia.* New Delhi: Sage Publication. p. 376.

gratuity whereas the maximum retirement gratuity payable is over 16 times the basic pay limited to Rs.3.5 lakhs[34].

I.Insurance Schemes for Senior Citizens:

Health and financial security were found to be the two most important challenges of ageing. Insurance is found to be a solution to these problems and thereby the following insurance policies have been introduced by the public and the private sector:

- **Jeevan Dhara:**

This Pension Plan is for those individuals who are self-employed, artists, technicians, in business, and professionals; as these individuals cannot have pension benefit after they cease to earn, compared to State/Central government employees who are endowed with 'pension' benefits. Age range at the entry to this scheme is between18 to 65 years and the minimum annuity per month is Rs.100. Presently, the scheme has been relaunched as '**New Jeevan Dhara 1**' with salient features as follows:

- ✓ It is a pure pension plan where in one pays single premium or regular premium over the deferment period to secure a pension starting at a future date.
- ✓ Policyholder can add a term assurance rider by paying additional premium. By the virtue of this rider, in the event of death of the policyholder during the deferment period, sum assured selected under term assurance rider would be paid.
- ✓ Annuity rates on the vesting date will be equal to that available under the New Jeevan Akshaya plan on the date of vesting.
- ✓ Bonus is payable under the policy. Contributions rank for IT rebate under section 88, though income benefits are taxable.
- ✓ Premium paying period is between 2 and 35 years. Policyholder has the option to pay a single premium or pay regular premium annually, half yearly, quarterly or monthly.

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34 *Ibid.* p377.

On Vesting (i.e. at the start of pension): The National Cash Option together with Reversionary Bonus and Final Additional Bonus (if any) with or without 25% commutation will be compulsorily converted into annuity having following options: Annuity for life ;Annuity for life with guaranteed period of 5, 10, 15 and 20 years ;Joint life and last survivor annuity to the annuitant and his/her spouse under which annuity payable to the spouse on death of the purchaser will be 50% of that payable to the annuitant, Life annuity with return of purchase price, Life annuity with annuities increasing at a simple rate of 3% p.a.

- **JeevanAkshay**:

For providing lifelong pension and lump sum death benefits this pension plan was introduced. This pension plan also provides a survival benefit at the end of seven years under certain terms and conditions. The minimum age at entry is 50 years and the minimum purchase price is Rs.10, 000, in multiples of Rs.100 thereafter. Dating back is not permitted in this scheme. JeevanAkshay Policies will not be issued under the Married Women's Property Act, 1874. This annuity cannot be assigned. This scheme is apt for elderly individuals since it relieves them from the hassles of reinvestment and provides them with timely returns on their investment. As long as investors between 30 and 75 have funds at their disposal and an inclination to gain a reasonable amount at periodic intervals, they will be provided with timely payments. This policy comes with three options:

- ✓ Regular annuity for life. Here, the individual will start getting the regular income through his lifetime but after his death, his family will not get anything.
- ✓ Annuity payments increasing yearly at three per cent. In this case too, the amount invested will not be returned to the family on death.
- ✓ Annuity for life with return of capital. Under this option, the family will get the invested amount on the death of the policyholder.

- **Jeevan Suraksha:**

Premium Ceasing Age under Jeevan Suraksha plan is 70 years. An exclusive non-medical limit of Rs.2 lakhs for purchasers up to the age 40 years has been permitted

for the plan. This scheme is meant for professionals and businessmen. Jeevan Suraksha Scheme is available in three types to suit individual needs, namely, pension with life cover, pension without life cover, and pension with endowment type. Salient features of the scheme are as follows:

- ✓ It offers a guaranteed pension for the life of the policyholder or a pension for the last survivor in case of a Joint life policy or a pension fund that will also return the purchase price paid by the policyholder.

- ✓ Terminal bonus is available and there is no forfeiture in case the premiums are discontinued. In case the life cover is not opted for, the policyholder also has the option of a single or one time premium payable.

- ✓ The policyholder also gains the option of a tax-free commuted value that amounts to nearly 25 percent. Premiums up to Rs.10,000/- qualify for 100 percent deduction from taxable income in terms of Sections 80 (CCC) of the Income Tax Act.

- ✓ The terminal bonus declared by the corporation on the vesting date depends upon the actuarial surplus on the pension fund and will increase the pension benefits.

- ✓ If the payment of premiums is discontinued, the policy is not forfeited completely. If premiums are paid for a full 3 years, the benefits are reduced on pro-rata basis.

- **Bima Nivesh:**

Life Insurance Corporation has launched a new "Bima Nivesh Plan 2002", offering an annual guaranteed return of around seven per cent per annum, after withdrawing its earlier scheme "New Bima Nivesh" which offered a guaranteed return of 8.28 per cent. The minimum age for entry is 35 years and maximum is 65 years (for a 10 years term), and 70 years (for a 5 years term) respectively. No medical examination is required. Only a simple declaration of good health needs to be submitted. This new scheme at a lower return is launched as earlier high-return scheme has become non-sustainable due to fall in interest rates. As the investment in Bima Nivesh will get tax exemption under section 88 of the Income Tax Act, the net rate of return would be even higher. Moreover, since the return is also tax free, the total effect of the tax

benefits make the return in the range of 10 to 13 per cent, depending on the tax slabs of the investors. In the new Bima Nivesh scheme, one can get a life insurance cover for 5 years and 10 years of Rs 1000, for Rs 985 and Rs 923 respectively. On maturity, the sum assured along with the guaranteed additions and loyalty additions, if any, will be paid on the expiry of the stipulated term.

Depending upon the Corporation's experience with regard to interest and expenses and based on terms of policy, loyalty addition maybe paid on maturity. On the Life assured surviving the stipulated date of maturity, Loyalty Additions may be paid at such rates and on such terms as may be declared by the Corporation. A Term Assurance Rider benefit payable by a single premium will be available at the choice of the proposer.

- **Senior Citizens Unit Plan:**

Under this scheme one has to make a onetime investment depending on his/her age and have the benefit of medical treatment for self and spouse at any of the selected hospitals on completion of 58 years of age. The Senior citizens Unit Plan has special arrangements with New India Assurance Co. Ltd.(NIAC) under an exclusive medical insurance cover where by the bills from the hospitals in connection with all medical treatment by the member will be settled directly by NIAC up to the prescribed limit. Age group of 18-54 years can join this scheme. The person may be a resident or a non-resident Indian. The person will be entitled for a medical insurance cover of Rs. 2.5 lakh after he/she attains the age of 58 years. This insurance cover is available for both the citizen and his/her spouse. After the age of 61 years both of them are eligible for a cover of Rs.5 lakh after adjusting to any claims made earlier. The citizen can avail medical treatment in any of the hospitals under this scheme. The Trust will call for all details about recent photograph, signature and address of the member and the spouse as soon as the member attains the age of 54 years so as to prepare an identity card and a log book for the member and the spouse

- **Medical Insurance Scheme:**

The medical insurance also known as Mediclaim is available to persons between the age of five years and seventy five years. Earlier, the sum insured varies from Rs.15, 000 to Rs.3 lakh and premium varies from Rs.175 to Rs.5, 770 per person per annum

depending upon the different slabs of sum insured and different age groups. The policy is now available to persons between the age of five years and eighty years. The cover provides for reimbursement of medical expenses incurred by an individual towards hospitalization/domiciliary, hospitalization for any illness, injury or disease contracted or sustained during the period of insurance.

- **Group Medical Insurance Scheme:**

This scheme is available to any group/association/corporate body of more than 100 persons having a Central administration point. The policy covers reimbursement of hospitalization and domiciliary hospitalization expenses only for illness/diseases contracted or injury sustained by the insured person. The basic policy under this scheme is Medi-claim only. This policy is available to person's b/w the age of five and eighty years. The sum insured varies from Rs.15, 000 to Rs.5 lakh and a premium varies depending upon the different slabs of sum insured and different age groups.

- **Jan Arogya:**

This scheme isprimarily meant for a larger segment of the population who cannot afford the high cost of medical treatment. The limit of cover per person is Rs. five thousand per annum. The cover provides for reimbursement of medical expenses incurred by an individual towards hospitalization/domiciliary hospitalization for any illness, injury or disease contracted or sustained during the period of insurance. The age limit for this scheme is 70 years.

- **Varishtha Pension BimaYogana:**

The Old-Age Pension Scheme of the LIC, called the 'Varishtha Pension Bima Yogana' was launched by the Indian Prime Minister on 14th July' 2003. It will provide a minimum pension of Rs.250 a month and a maximum of Rs.2,000 a month to people over 55 years of age who opt for the scheme. For the minimum pension, a lump sum payment of Rs.33,335 has to be made while for the Rs. 2,000 scheme Rs.266,665 has to be paid. There is no upper age limit for availing the scheme and in the case of the death of the pensioner, the purchased price will be returned to the nominee. The assured rate of return worked out by the LIC is nine percent per annum.

In case the LIC earns lower returns on the corpus of the scheme, the government would step into make up the shortfall.

- **Private Pension Plans:**

Private companies like that of ICICI Prudential Life, HDFC Standard Life, Aviva Life and ING Vysa etc. have launched their own pension plans for elderly[35].

J. Mention of Senior Citizens in Five Year Plans:

Even though Five Year Plans do not show any consistency in recognizing the seniorcitizens as a target group but still there is some mention of the aged in the Five Years Plan. Therefore all these plans along with the participation of India in second World Assembly of Ageing have been highlighted as follows:

- **The First (1951-1956) and Second Five Year Plans (1956-1961)**

There is no mention of senior citizens in the first two plans of government. They covered only the social security measures for industrial workers. Hence, they are of no relevance to aged.

- **The Third Five Year Plan (1961-1966)**

Third planrecognized the needs of the old living without any means of livelihood and support but still the issue was left to voluntary organizations and local bodies to provide the assistance. Plan suggested for the setting up of relief and assistance funds. Another interesting consequential development was a communication from the Ministry of Labour, Government of India, to the State governments in 1963, exhorting the setting up of Social Assistance Bureau by civic bodies and the establishment of Relief and Assistance Funds which would be administered through the Social Assistance Bureau; some assistance was stipulated from the central government for such funds. However, nothing positive emerged and the outlay of Rupees twenty million made for social assistance programmes covering the old and other categories remained unutilized.

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35 Ibid.

- **The Fourth Five Year Plan (1969-1974)**

The fourth plandocument made a provision of rupees forty million especially for the social assistance schemes for old persons who are unable to work, the physically handicapped and other categories. But this fund remained unutilized in the first two years. Hence this plan also proved to be unsuccessful in fulfilling the expectations of senior citizens.

- **The Fifth Five Year Plan (1974-1979)**

In the fifth plan it was mentioned that the states should progressively endeavours to evolve a comprehensive social security system covering the needs of the aged, the handicapped and others in need of social assistance. No outlays were, however, provided in the central plan. It was presumably left to the state to carry out the directives through appropriate programmes in the State plans. Thus progress in this direction was very inadequate as due to financial crisis of States. Plan was also limited to running or giving grants-in-aid for Old Age Homes as the first programme which struck the mind was institutional care in Old Age Homes.

- **The Sixth Plan document (1980-1985)**

Sixth plan also had no mention of the ageing and the aged as a target group needing welfare services. The subsequent sixth plan (1980-81 to 1984-85) document which superseded this; recognized the aged as a vulnerable group of whom programmes were required to be developed to meet their needs. No outlays were separately indicated in the central sector for schemes for the aged, the assumption once again be the same that the States could in their plans provide whatever services they felt as necessary. However, the State plans continued to treat this as a low priority sector. In 1983-84, it was for the first time, as a fall out of the World assembly on ageing; the central government started giving grant-in-aid to voluntary organizations for providing services to the elderly under 'grants-in-aid' scheme.

- **The Seventh Plan (1985-1989)**

Like the previous plans, thisdocument does not gaverecognition to ageing as a target group; nor has any mention been made of their needs or services to meet those needs.

However, as in the Sixth Plan, grants-in-aid scheme of the Central government would continued; in the States, too, grants were being given to voluntary organizations or Old Age Homes run by the government, but budgetary provisions were very small[36].

- **Eighth Five Year Plan(1992-1997)**

During the Eighth five year plan, welfare measures for the elderly were found more specific and comprehensive. In November 1992, the Ministry of Welfare initiated 'Welfare of the Aged' scheme to encourage voluntary organizations through grant-in-aid assistance to provide old age homes, day care centers, mobile Medicare and non-institutional services for older persons above the age of sixty. The scheme marks the entry of the ageing population as a target group in national planning and recognizes the voluntary sector as constituting an important institutional mechanism in providing services complementing the endeavors of the state. By 1995, 212 Old Age Homes, thirty one Mobile Medicare Units, and a number of day care centers set up by the voluntary sector received assistance from government funds marked for the purpose. However, since the scheme did not specify the services to be provided, no proper monitoring/evaluation was carried out. Consequently, there was no worthwhile assessment of the functioning of the scheme.

K. The Madrid International Plan of Action:

In response to a series of comments from different countries, the Second World Assembly on Ageing was held in Madrid (Spain) in April 2002 and hence resulted in the formulation of a new international Plan of Action for aged .The plan of action calls for changes in attitudes, in national and international policies, and in community, corporate and organizational practices, so that the enormous potential of ageing in the Twenty-First century is fulfilled. It seeks to ensure that people everywhere will be enabled to age with security and dignity. They also should be able to continue to participate in their societies as citizens with full rights[37].

Thus Madrid Plan was the first international agreement to recognize the potential of older people to contribute to the development of their societies and to commit

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36 Gangrade, K.D. and Bose, A.B. (1988).*The ageing in India: Problems and potentialities*. New Delhi: Abhinav Publications. pp.61-62.

37 Prakash, I.J. (2005). *Research Agenda in Gerontology*.In Indira, J. P. (Ed.).Ageing in India: Retrospect and Prospects. CCR-IFCU.Project Report on Ageing and Development. p.42.

governments to include ageing in all social and economic development policies. This plan has set the tone for national initiatives to ensure active participation of older people in governance and in elimination of their neglect, abuse and violence.The Plan of Action has the following policy directions:

i. Older Persons and Development:

It includes active participation of elderly in society and development work; rural development; migration and urbanization; access to knowledge, education and training; intergenerational solidarity; eradication of poverty, income security and poverty prevention. The recommendations under the development priority include:

- The government must take concrete measures to protect and assist older persons in situations of armed conflict and foreign occupation, including providing mental and physical rehabilitation services for those disabled in such situations.
- To give importance to alleviate poverty by stressing for ensuring sufficient minimum income for all older persons. There is recognition that where poverty is endemic, people who survive face a lifetime of poverty and it further depends in old age. Thus sustainability in the provision of adequate income security should be given great importance.
- To focus on involving older persons in decision-making, creating employment opportunities for those who wish to work, improving living conditions and infrastructure in rural areas.

ii. Advancing health and well-being:

It includes health promotion, well-being throughout the life course, universal and equitable access to health care services, older persons and HIV/AIDS, training of care providers, mental health needs of older persons and older persons with disabilities. The recommendations under the health priority include:

- Provision of continuum of care, ranging from health promotion and disease prevention to the provision of primary care and acute treatment for older persons.
- Putting stress on life course perspective to ageing and bringing focus on maintaining independence, prevention and delay of disease and disability.

- Improving assessment of the impact of HIV/AIDS on older person's health and providing adequate information and training to people living with HIV/AIDS and their informal caregivers.
- To expand educational opportunities in the fields of Geriatrics and Gerontology and also programmes on health and older persons for professionals in the social service sector.

iii. Ensuring enabling and supportive environments:

It brings attention to the issues of housing, living environment, care, abuse, violence and images of ageing. The recommendations under the supportive environments include:

- Improvement in the housing and living environment of older persons.
- Promoting a positive view of ageing and enhancing public awareness of the important contributions of older persons.
- The availability of accessible and affordable transport for older persons.
- Providing a continuum of care and services for older persons, supporting the

Caregiving role of older persons and creating support services to address the elder abuse are important dimensions of this priority[38].

Thus for India and other nations, the adoption of Madrid Plan of Action at the Second World Assembly is a commitment to act to meet the challenges of ageing . It gives importance to age relatedresearch, areas of education and training, empowerment of older persons, and the need to create opportunities for older persons to continue working for as long as they wish. It provides a framework to the government to take the implementation of NPOP ahead and to a wider context with greater seriousness and intentions.

Hence, the position of aged in five years plans reflectedthat social security of aged has been given lowest priority by the government. It was only recently i.e. after the second World Assembly on Ageing and the formulation of National Policy for Older Persons; the government decided to work for the welfare of senior citizens. The most

38 Bose, A. and Kapur, M. (2004).*Growing old in India: Voices Reveal; Statistics Speak.* New Delhi: B.R Publishing Corporation. pp.186-190.

important initiative was the provision of special Act for the maintenance and welfare of the aged. The Act with its important features is given as follows:

L. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007[39]:

The Maintenance and Welfare of Parents and Senior Citizens Act shall come into force in all Indian States (except the J and K) on December'2007. The Act aimed at helping the elderly to live in dignity and peace. The major highlights of the Act are:

- The Act requires children who are not minors and relatives who are legal heirs of senior citizens are expected to maintain elderly parents or relatives. A person unable to maintain self is entitled to make an application for maintenance by children or a relative who may be in a possession of the property of such person.
- "Maintenance" includes provision for food, clothing, residence, medical attendance and treatment.
- The Act proposes to provide for appropriate mechanism to be set up to provide need-based maintenance to the parents and senior citizens.
- The Act caps the maximum monthly allowance at Rs. 10,000 per month. Punishment for not paying the required monthly allowance shall be Rs.5, 000 or up to three months imprisonment, or both.
- In case of any denial from the side of children in providing maintenance; an application may be made by a senior citizen or parent and, if such person is incapable, by any voluntary organization registered under Societies Registration Act, 1860 on behalf of the person.
- The Maintenance Tribunal constituted under the Act may order interim relief if the proceedings are found pending. The provision is also made to dispose the proceedings within 90 days from the date of service of notice of the application.
- District Social Welfare officer, having the powers of First class Judicial Magistrate will be designated as a "Maintenance Officer" and shall represent a parent or senior citizen during the proceedings of the Tribunal.
- The Act also recommends that the State governments may establish and maintain Old Age Homes at the least one in each District to accommodate a minimum of 150 senior citizens who are indigent.

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39 The Maintenance and Welfare of Parents and Senior Citizens Act, 2007.Bare Act. Universal Law Publishing Co. Pvt. Ltd. New Delhi-India.

- The Act also provide for institutionalization of a suitable mechanism for 'Protection of Life and Property of Older Persons'.
- The Act also recommends the State governments to provide for medical care including the facilities of separate beds and queues in hospitals; treatment and research activities for chronic, terminal and degenerative diseases.
- The Act has made no provision to provide for emotional and psychological support and care to the senior citizens, particularly those above the age of seventy and widowed women.

The analysis of above mentioned welfare schemes and policies of senior citizens reflects that elderly constitutes a vulnerable group; even the constitution put the senior citizens into the category of weaker and marginalized section along with women and children. On recognizing their vulnerability; the government had initiated a lot of intervention packages and schemes meant especially for their welfare. Strategies have also been designed to put these policies into action. But still their position remains unaltered. The main problem lies in the implementation of these services. What has been designed is not transferred properly to them and thus their vulnerability continues to persist. Therefore, in the next chapter findings of the present study have been discussed so that we got a more clear perspective of the ageing phenomenon.

CHAPTER III

FINDINGS
&
DISCUSSIONS

FINDINGS AND DISCUSSIONS

FINDINGS RELATED TO SOCIO-ECONOMIC PROFILE OF RESPONDENTS

Under socio-economic profile various characteristics like age, marital status, religion, caste, education, type of housing, family size, living space, financial income, financial assets, savings, health problems, mode of treatment, health insurance and helping aids as a means of coping, nature and form of abuse, coping practices and healthy behaviors etc. have been analyzed which are discussed as follows:

3.01: Age-wise distribution of respondents

Age is one of the most important demographic variables usually defined as the number of completed years, elapsed since the birth of the individual. Although it is a biological factor but it has its social significance. It helps in determining physical, mental and social changes in the life of an individual. It also determines an individual's marital, financial and health status. The usefulness of involving 'age' as a variable under present study is more visible, when it is cross classified with variables like health problems; pattern of sleep; decision making and capacity to do Activities of Daily Living. Thus age as a variable has significant value in the present study.

Table 3.01: Age-wise distribution of respondents

S.No	Age of Respondents (in yrs.)	No of Respondents	Percentage (in percent)
1	Young- old (60-69)	270	54.00
2	Old-old (70-79)	164	32.80
3	Oldest-old (80 and above)	66	13.20
	Total	**500**	**100.00**

The Table 3.01 gives the description of the age-wise composition of the respondents. For the sake of simplicity, all the respondents have been classified in three distinct categories vis. Young-old (60-69 years), old-old (70-79 years) and oldest-old (80 years and more) respectively. The above table clearly reveals that out of the sample of 500 respondents, the majority (54 percent) falls in the age group of young-old (60-69

years) elderly. The next highest percentage falls within the age group of 70-79 years (32.8 percent) which constitutes the old-old age group whereas the remaining respondents (13.2 percent) belong to the oldest-old age group (80 years and above).

The basic reason behind the lowest composition of oldest-old age group is their health problem. Due to health imbalances, the oldest-old respondents were unable to talk and sit in long settings. But still the age in the sample ranges from 60 to 94 years with the majority of respondents falling within the category of 'young-old' only. Almost similar compositions were used by R. Bakshi[1] et.al in their study based on 240 rural and urban elderly in Punjab where the sample includes 58.34 percent rural and 51.67 percent urban elderly falling in the 'young-old' age category, 24.16 percent rural and 26.67 percent urban in the 'old-old' and 17.5 percent rural and 21.66 percent urban in the 'oldest-old' age category respectively.

3.02: Gender-wise distribution of respondents

In old age 'gender' as a variable helps in determining the significant differences in practices associated with dietary intake, social security, pattern of adjustment and religious pursuits.

Table 3.02: Gender-wise distribution of respondents

S. No	Gender	No of Respondents	Percentage (in percent)
1	Female	247	49.4
2	Male	253	50.6
3	**Total**	**500**	**100.0**

Table 3.02 clearly reveals the gender-wise distribution of respondents and found that the majority of respondents were male 253(50.6 percent) followed by 247 females (49.6 percent).The gender-wise concentration within the three age categories vis. young-old, old-old and oldest-old was also determined to identify the age specific gender differences. The findings indicated that out of the total number of male respondents (253); 132belong to 'young-old', 86 to 'old-old' and remaining 35 to the 'oldest-old' age category. In case of female respondents; out of the total number of

1 Bakshi. R, et. al. (2007). *Problems of the Aged living with families and in senior citizens homes: A comparative study.* In Indira, J. P. (Ed.). Aging strategies for an active old age. 7th volume.The Aging and Development Project. CCR-IFCU Publications. p.68.

females (247); 138 belong to the 'young-old', 78 to 'old-old' age and remaining 31 belong to the 'oldest-old' age category. Hence, the sample comprises of almost equal number of male and female respondents. Similar composition was used by P.S. Anklesariaet.al[2] in their study comprising 677 elderly people including 395 males and 284 females.

3.03 Religion-wise distribution of respondents.

Religion is also a social variable. In old age, majority of senior citizens get associated with religious practices. The reason of including religion in the present study is to administer the effect of religious beliefs and behaviours in the life of senior citizens. The basic aim is to check whether religion is making any impact on the life styles and coping practices of senior citizens or not.

Table 3.03: Religion-wise distribution of respondents.

S. No	Religion	No of Respondents	Percentage (in percent)
1	Hindu	220	44.00
2	Muslim	280	56.00
3	Others	Nil	Nil
	Total	**500**	**100.00**

The above table clearly highlighted the dominance of two religious groups in the sample as majority of respondents were Muslims (280) followed by Hindus (220).There was no respondent belonging to any other religious group. This shows that the wards selected for study were densely populated with people belonging to either Hinduism or Islam. This also matches with the religious distribution of the total population of Aligarh where highest proportion is of Hindus(81.49 percent)and Muslims(17.78 percent) only. However, the population practicing other religions including Sikhism and Christianity was only (0.73 percent) (Census data, 2011)[3].

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2 Anklesaria, P.S. (1996). *Demographic and clinical characteristics of the elderly urban people.* In Kumar, V. (Ed.). Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology. India. p.26.

3 updes.up.nic.in

3.04: Marital status of respondents

Marital status has significant impact on care giving, social interaction and other social roles being performed by the elder population. Imperative roles and responsibilities have been assigned to an individual on the basis of his/her marital status. It is believed that those who are married and are living with their spouse are facing lesser financial, psychological and care giving problems as compared to those who are never married, widowed, and separated. The married elderly have better adjustment as compared to other marital categories. Hence, distribution of respondents according to their marital status has been checked and given as follows:

Table 3.04: Distribution of respondents according to their marital status.

S. No	Marital Status	No of Respondents	Percentage (in percent)
1	Married and living together	331	66.20
2	Married but separated	03	0.60
3	Widow/ Widower	161	32.20
4	Unmarried	05	1.00
	Total	**500**	**100.0**

The above table clearly reveals that the majority (66.20 percent) of respondents were married and were living with their spouse. This shows the universality of marriage. This was followed by the number of widows / widowers (32.2 percent). The percentage of unmarried respondents is also very low i.e. only one percent. The above finding clearly reveals the fact that the present elder generation is in a habit of giving full acceptance to social institutions of family and marriage. Similar findings were reported by Usha Bambawale[4] (56.25 percent married) and P.S. Anklesaria et.al[5] (81 percent married) in their respective studies. It was also observed that the higher percentage of married and living together respondents belongs to 'young old' and 'old-old' age groups ,whereas, the majority of widowed and widower are from the 'oldest-old' age group only.

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4 Bambawale,U. and Streevan. (1996). *Abuse of the Aged.* In Kumar, V. (Ed.). Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology, India. p.301.

5 Anklesaria, P.S. (1996). *Demographic and clinical characteristics of the elderly urban people.* In Kumar, V. (Ed.). Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology, India. p.26.

3.05: Educational status of respondents

Table 3.05 shows the education wise classification of respondents. Education has a direct impact on the source of earning and standard of living of an individual. Higher the level of education; more will be the individual's awareness of social security measures.

Table 3.05: Educational status of respondents

S. No	Educational Status	No of Respondents	Percentage (in percent)
1	Illiterate	173	34.6
2	Up to Primary	76	15.2
3	Up to Middle	48	9.6
4	High school	59	11.8
5	Intermediate	20	4.0
6	Graduation	34	6.8
7	Post Graduation	35	7.0
8	Professional course	29	5.8
9	Ph.d/Higher degree	26	5.2
	Total	**500**	**100.0**

It is clearly evident from the Table 3.05 that majority of respondents 173 (34.60 percent) were illiterate. Out of literates, 327 (65.40 percent); 76 (15.2 percent) were educated till primary level, 48 (9.6 percent) till middle class, 59(11.8 percent) till high school and 20(4.0 percent) till intermediate level. The corresponding percentages for graduates and post graduates were 6.8 and 7.0 percent respectively. Besides, 29 respondents (7.0 percent) were having some Professional degrees like B. Tech, M. Tech, M.B.A, LL.B etc. and merely 25.8 percent have done their Ph.ds or D.Lit. These results go substantially in line with the observations of R. Bakshi et.al[6], Laxmikant, S.

6 Bakshi, R. et. al. (2007). *Problems of the Aged living with families and in senior citizens homes: a comparative study*. In Indira, J. P. (Ed.). Aging strategies for an active old age. 7th volume of the Aging and Development Project. CCR-IFCU Publications. p.68.

Talunker and John A. Menachery[7], R.K. Punia et.al.[8], S.Kaur and M. Kaur[9] and ArchanaKaushik Panda[10].

3.06: Living pattern of respondents: Nuclear vs. Joint family

Table 3.06 indicates the type of family in which the respondents are living. In the study, family groups have been classified into two broad categories, namely, Nuclear and Joint.

Table 3.06: Living pattern of respondents: Nuclear vs. Joint family

S. No	Family Type	No of Respondents	Percentage (in percent)
1.	Nuclear	220	44
2.	Joint	280	56
	Total	**500**	**100.0**

Nuclear family is one where an aged person stays with his/her spouse and/or unmarried children or living alone in a single household, whereas, in joint family system; aged people used to stay with spouse and /or married children. The data presented in Table 3.06 discerns that overwhelming majority of respondents 280 (56 percent) were living in joint family system .This is because in Aligarh, the family ties have been given due recognition. But unfortunately, the rapid pace of urbanization and better employment opportunities outside city has all started migration in Aligarh resulting in nuclear families. In addition, the poor financial status was responsible for the existence of nuclear family in cities. As a result of poverty, the children left their parents unattended to face social and economic hardships.

In the present study, out of 500 respondents, 280 (44 percent) were living in nuclear family system and remaining were still in a practice of living with joint family (56 percent). These findings are fully supported by the findings of P. Mohanan and Sajjan

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7 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280-284

8 Punia, R.K. and Malik et.al.(1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak T.M and Sharma M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. pp.56-63.

9 Kaur, S. and Kaur, M. (1987). *Psychological Problems of the Aged.* In Dak T.M and Sharma M.L. (Ed.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.76.

10 Panda, A.K. (2008). *Elderly Women in Madhya Pradesh: Condition and Challenges.* In HelpAge India.RandD Journal. Vol. 14. No.2 May.

B.S[11]where majority (71percent) of elderly respondents were living in a joint family system followed by nuclear family (26.4 percent) and remaining 2.6 percent were living with son-in-laws and relatives. Dr. N. Swarnalatha[12]also observed similar kind of findings in her study based on rural areas of Chittoor district of A.P. with a sample size of 400 elderly. She found that 62.5 percent of the respondents were living in joint family and only 4percent were living alone. Following similar pattern, P. Sandu and R. Bakshi et. al;[13] in their study based on 240 elderly women belonging to rural and urban areas of Punjab observed that 95percent rural and 72.5percent urban were living in Joint family system, whereas a very small percentage i.e. only 5percent rural and 27.5percent urban used to reside in nuclear family.Similar findings have been reported by Padma Mohanan et. al[14] in Mangalore. Contrarily to above findings, C. J. Thomas and Fiasta T. Diengdoh[15]in their project on Ageing in Meghalaya based on 231 elderly found the prevalence of nuclear families in cities. The study reflected that out of 231 elderly respondents, 187 belong to nuclear family, 40 to joint family and only 4 to extended family. Similar pattern was reflected in the study of Usha Bambawale[16] based on 864 women elderly of Pune. The study reported 44.1 percent Nuclear Families, 25.7 percent Joint families, 28.8 percent aged living alone, and 1.4 percent did not reply. In another study conducted on the problems and social adjustment of the retired elderly of Chandigarh and Jabalpur; Saraswati Mishra[17] came up with similar results. In both the cities, Nuclear family was found to be the most common practice as compared to joint family. This shows that with the advancement of society towards

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11 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi-dimensional approach.* In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing and Development. p.81.

12 Swarnalatha, N. (2008). *Chapter: A study on health of aged women in rural areas of Chittoor district.* In HelpAge India. Research and Development Journal. Vol. 14. No.1. June Issue. p.20.

13 Sandhu, P. and R. Bakshi. et. al. (2007). *Health Profile of the rural and urban elderly women of Punjab State.* In Prakash, I. J. Aging: Strategies for an active old age. vol. 7. Aging and Development project. CCR-IFCU Publications. p. 10.

14 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi-dimensional approach.* In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing and Development. p.91.

15 Thomas, C. J. and Diengdoh, T. F.(2007). *Project report on Ageing in Meghalaya.* ICSSR North Eastern Regional Centre, Shillong, Meghalaya and Directorate of Social Welfare. Government of Meghalaya. Shillong (Research Thesis). p.97.

16 Bambawale, U. and Streevan. (1996). *Abuse of the Aged.* In Kumar, V. (Ed.). Ageing: India Perspectives and Global Scenario.Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology, India. p.301.

17 Mishra, S. (1989). *Problems and social adjustment in old age: A sociological analysis.* New Delhi: Gian Publication House. p. 245.

modernism; the joint family system is disappearing and the concept of nuclear and single family is emerging.

3.07: Family Size of respondents

The size of family determines the number of caregivers available during old age. It also helps in analyzing the savings by looking into the source of earning and expenditure of the family. It was generally found that those with having less income and larger family size may face economic hardship in old age and hence the variable family size has its own significance. Table 3.07 shows that majority of the respondents 197(39.4percent) were living in a medium size family i.e. between 3 to 6 members followed by 130 respondents (26 percent) belonging to small family (husband-wife only), 92 respondents (18.4 percent) to large family, 57 respondents (11.4 percent) to very large family (above 10) and only 24 (4.8 percent) respondents were living alone.

Table 3.07: Family- size of respondents

S. No	Family Size (no of members)	No of Respondents	Percentage (percent)
1	Very Small (living alone)	24	04.8
2	Small (up to 2)	130	26.0
3	Medium (3-6)	197	39.4
4	Large (7-9)	92	18.4
5	Very Large (above 10)	57	11.4
	Total	**500**	**100.0**

The findings also reveal that overwhelming majority of respondents 476(95.2 percent) has someone to look for and thus they do not need any type of formal care giving. In this regard, Dr. R. Kasthoori[18]observes that larger the family size, more will be the attention received by the elderly and hence more satisfaction they had with life. This will also bring greater support and no change in attitude of family members towards them as compared to those who are living in smaller families. Following similar trend;

18 Kasthoori, R. (1996). *The problems of the aged: A sociological study.* New Delhi: Uppal Publications. p.94.

D. Bansod and B. Paswan[19] in their study on Old age Homes of Maharashtra also found strong association between family size and shift to old age home as 81.8 percent of the respondents joined the Old Age Home because of care giving problem as they had no caregiver available at home followed by the reason of migration of children (24.5 percent) and loneliness (69.8 percent).

3.08: Distribution of respondents on the basis of their housing conditions

In the present study, 'Housing condition' was introduced to know the financial and health status of the respondents. For the sake of simplicity, the housing conditions have been classified into three categories, namely: poor, average and good. The poor housing is one where total sanitation is absent, there was no drainage system, no toilet and bathing facility present within their premises and houses were generally made of straw, tin and mud etc. An average house, on the other hand, includes semi-pucca structure with having one or two rooms along with toilet and bathing facility. Drainage system is also found to be open. In contrast, the Good housing includes the well-furnished pucca houses with having well furnished rooms, hygienic toilet, bathroom and good drainage system. Besides, there was privacy for everyone living in the house. Hence, the distribution of respondents on the basis of their housing condition has been given as follows:

Table 3.08: Distribution of respondents on the basis of their housing conditions

S.No	Housing Condition	No of Respondents	Percentage (in percent)
1	Poor	61	12.2
2	Average	88	17.6
3	Good	351	70.2
	Total	**500**	**100.0**

The above findings clearly reveal that overwhelming majority of respondents (70.20 percent) are living in good housing conditions followed hy average (17.6 percent) and poor housing (12.2 percent). It was further noticed that the poor housing condition

19 Bansod, D. and Paswan, B. (2006). *From Home to Old age Homes: A situational appraisal of elderly In Old Age Home in Maharashtru.* In Help Age India Research and Development Journal. vol. 12. no.3.p.16.

was generally observed by the respondents belonging to low income group or the labour class, whereas, the respondent belonging to higher income group (those earning 30,000 Rs. and above) are enjoying living in good housing conditions. The reason being the amount of money which the labour class was getting is insufficient in maintaining the basic needs and proper sanitation. Following similar line, Dr. N. Swarnalatha[20] in her study based on rural elderly women found that majority of respondents (52.7 percent) were living in kutcha houses followed by 47.3 percent respondents living in pucca house. This shows that in rural areas the practice of living in kutcha house is still dominant.

3.09: Distribution of respondents according to their migration pattern

In old age, migration to unknown areas may become a social threat. On getting migrated, the elderly faces many problems e.g. separation from their near ones including friends and relatives may bring a feeling of isolation and boredom to them, which in turn put them under sheer stress and isolation. It also affects their eating habits and confidence retaining skills. In new place, the elderly felt even afraid of doing their simpler tasks. They do not prefer to go outside and make new friends. Hence, migration affects both the social as well as psychological health of senior citizens.

Table 3.09 Distribution of respondents according to their migration pattern

S.No	Migration within last 10 years	No of Respondents	Percentage (in percent)
1	No	437	87.4
2	Yes	63	12.6
	Total	**500**	**100.0**

The present table indicates that out of 500 respondents, only 63(12.6 percent) respondents had reported migration to Aligarh within last one decade. The reason for their migration were studied and were reported as retirement from service, shift to ancestral home in Aligarh, children's job in Aligarh, treatment of chronic illnesses, communal riots, dependence on children due to death of spouse etc. The remaining

20 Swarnalatha, N. (2008). *Chapter: A study on health of aged women in rural areas of Chittoor District.* In Help Age India. Research and Development Journal. Vol. 14. No.1. June Issue. P.20.

437 respondents had either shifted to Aligarh more than ten years back or were born there. This shows that majority of respondents were familiar with the city of Aligarh. Further, they had all their near ones either living with them or reside near them. Hence, migration has no significant impact on the life of majority of respondents. Similarly, R.K. Punia et.al[21] in their study based on rural-urban differentials reported that majority of the rural (99percent), and 55.38percent of the urban aged were born in rural community. Majority of the aged (56.92percent) born in rural community migrated to urban community at the age of 21 years and above followed by respondents having migration in between 15 to 20 years of age and below 14 years of age. Hence, there is found no impact of migration on the life of these respondents.

3.10: Problems associated with migration in old age

Table 3.10 indicates the problems associated with migration of senior citizens. It was clear from above table that out of 500 respondents, only 63 (12.6 percent) were facing the outcomes of migration, whereas 435 (87.0 percent) respondents had never face any problem related to migration in old age.

Table 3.10 Problems associated with migration in old age

S. No	Problem with migration	No of Respondents	Percentage (in percent)
1	Loneliness	19	30.15
2	Reduce social interaction	16	25.39
3	Adjustment problem	28	44.46
	Total	63	**100.0**

The present findings indicate that only 63 (12.6 percent) respondents had reported migration to Aligarh within last one decade. Out of those who migrated 'adjustment' was found to be the most frequent problem associated with migration (44.46 percent) followed by the problem of loneliness (30.15 percent) and reduced social interaction (25.39). Hence, from the above findings it can be inferred that there is as such no impact of migration on the life of majority of senior citizens as they were all settled very long back in Aligarh. The elderly reported differences in ideologies and improper living space as the basic reason behind the maladjustment in old age. In

21 Punia, R.K. and Malik et.al.(1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.58.

addition, physical immobility doesn't allow them to meet their friends and near ones. All these factors go together and make the elder vulnerable.

3.11: Distribution of respondents according to their privacy at home

Man is a social animal with some personal needs. Everyone needs privacy in life. In old age the privacy becomes more important as the aged people want to maintain some distance with their family members in doing their activities of daily living e.g. in performing religious practices, taking rest, watching T.V. and chatting with friends etc. Table 3.11 indicates that majority of respondents 313 (62.6 percent) had a separate room of their own whereas 187 respondents (37.4 percent) either shared it with other family members or live in veranda, open space or lobby. This was because of unavailability of sufficient space at home and also due to larger family size

Table 3.11: Distribution of respondents according to their privacy at home

S. No	Private space availability	No of Respondents	Percentage (in percent)
1	No	187	37.4
2	Yes	313	62.6
	Total	**500**	**100.0**

3.12: Distribution of respondents according to their proximal distance from siblings

Table 3.12 indicates that overwhelming majority of respondents 403 (80.6 percent) had at least one of their children living within the same city. Out of remaining; 46 (9.2 percent) respondents had their children living in different cities, 41(8.2 percent) had children settled abroad and only 10 respondents (2 percent) had no siblings. This shows that majority of respondents had someone to look for. In case of care giving, it was found that an overwhelming majority of respondents (341) had their children surrounding them at the time of illness and any other problem. However, 159 respondents were not getting any kind of support from their siblings. Further on checking the impact of proximal distance of respondents from their siblings; it was found that proximal distance as such play no role in care receiving as almost similar proportion of care giving was received by respondents whose children are living

either near to them or in the same city as 73.90 percent reported help received from children living with them, 58.69 percent received care by children living in different city. However, a significant loss of care receiving was observed by the respondents whose children are living abroad as only 39.02 respondents received the caregiving out of them. The findings also reflected that those who were not getting any support from their siblings are generally from lower income group. This shows that living apart from parents does not make a significant impact on family ties and social contacts.

Table 3.12: Distribution of respondents according to their proximal distance from sibling and care giving received.

S. No	Proximal distance of respondent from sibling	Siblings providing care giving at the time of illness			Percentage (in percent)
		YES	NO	Total	
1	Low (living in same city)	298 (73.94%)	105 (26.05%)	403	80.6
2	Moderate(living in different city)	27 (58.69%)	19 (41.30%)	46	9.2
3	High (living abroad)	16 (39.0%)	25 (60.97%)	41	8.2
4	Not applicable (No children)	NA	10	10	2.0
	Total	**341**	**159**	**500**	**100**

3.13 Feeling of loneliness and isolation among the respondents

Loneliness is also found to be an important problem in old age. The present study indicates that almost all of the respondents were feeling loneliness in one stage or the other, however, the degree of loneliness may vary. Out of the total of 500 respondents, 368 (73.6 percent) reported loneliness sometimes, whereas, 132 (26.4 percent) reported the feeling of loneliness always. The main reason of feeling loneliness includes spouse's death and children's lack of interest towards them. The respondents complained that their children generally asked them to live in separate rooms or places and without showing any kind of interference in their lives. As a result, the respondents feel insulted and preferred to be lonely and isolated. Isolation

is also observed because of deprivation of respondents in terms of their income, status and authority.

Table 3.13: Feeling of loneliness and isolation among the respondents

S. No	Feeling of loneliness	No of Respondents	Percentage
1	Low(sometimes/occasionally)	368	73.6
2	High(always/most of the time)	132	26.4
	Total	**500**	**100.0**

Thus from above findings it can be easily concluded that as age advances, more and more people develop a feeling of isolation and loneliness. Observation of N.K. Chadha et. al.[22]also go in line with the present findings. His findings reveal that most of the senior citizens felt lonely even in the midst of people. The reason they cited for loneliness was the loss of peers, spouse and cohorts and hence they do not have people with whom they can relate themselves to pour their woes and emotions.

In another study, N. P. Devi and P.T. Murgesan[23] related loneliness with that of depression. He found that 19 percent of the elderly respondents in his study felt depression just because of loneliness, 55 percent felt loneliness due to helplessness and 13percent due to boredom respectively. In addition, the findings of C. J.Thomas and Fiasta T. Diengdoh[24] also found that the majority of the respondents (127) felt lonely in old age.

Further he explains the reasons for being lonely as financial hardship (38 percent), health problems (13 percent), poverty (10percent), staying away from children (10 percent), and death of spouse (6percent). In contrast with these findings, Satnam kaur and Malkit kaur[25]in their study noticed that majority of respondents (51.67 percent) were not feeling loneliness in their life as compared to 36.66 percent respondents who felt loneliness 'seldom' and 11.67 percent feeling loneliness 'always'. Similar is the case with social isolation where least isolation is reported by 23.33 percent

22 Chadha. N.K.et.al. (2006). *Psychological health of the elderly- age and gender issues.* In ageing and society: Indian Journal of Gerontology. Vol.XVI, NO.I and II. Jan to June Issue. p. 37.

23 Prabhavathy, D. N. and Murgesan, P.T. (2007). *Socio- Economic profile of the institutionalized Elderly.* In Prakash, I. J. Aging: Strategies for an active old age. vol. 7. Aging and Development project. CCR- FCU Publications. pp.52-59. (330)

24 Thomas, C. J. and Diengdoh, F. T. (2010). *Ageing in Meghalaya.* New Delhi: Akansha Publishing House. Vol. 6.p. 97.

25 Kaur, S. and Kaur, M. (1987). *Psychological Problems of the Aged.* In Dak, T.M. and Sharma, M.L. (Ed.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.76.

respondents, moderately by 20 percent and highly by 16.67 percent respondents respectively.

3.14: Respondents' share in decision making of household matters

Table 3.14 indicates that almost half of the respondents (47.2percent) had shifted their decision making power to someone else in the family. However, almost equal share of the respondents 264(52.8percent) reported that they were still in a position to take decisions especially in a matter of children's education (56 percent), marriage (71 percent), household expenditures (46 percent) and religious activities (83 percent) etc. Those respondents who are not in a position to take decisions generally belong to old-old age group. In addition, they were financially dependent on their family members for their everyday needs.

Table 3.14: Respondents' share in decision making of household matters

S. No	Decision makers	No of Respondents	Percentage (in percent)
1	No	236	47.2
2	Yes	264	52.8
	Total	**500**	**100.0**

However, those respondents who are living in nuclear family and belong to higher income group were not having any such problem of decision making. Instead, they were the decision makers of all their affairs. This shows that although rising age and income dependency both play a significant role in decision making but the family values are equally important. The majority showing its share in decision making, as noted above, is just because of the cultural practice of giving respect to their parents. This shows that although Aligarh is in a rapid pace of urbanization but its cultural practices are still pertinent. Findings of R.K. Punia et.al.[26]in Hissar city and its surrounding rural area fully supported the present observations as it was highlighted that 74 percent urban and 65 percent rural household considered themselves as head of their family. However, 23 percent urban and 29 percent rural considered their son

26 Punia, R.K. and Malik et.al.(1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak, T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publication. pp. 56-63.

as the head. Moreover, many studies were conducted to identify the individual share in decision making in various socio-economic activities. For instance, the study of Madhu Jain and Ambika Sharma[27] highlighted that 60 percent respondents were having satisfactory relationship with their family. Almost half of the respondents were consulted for matter related to education, festival, and social ceremony; three-fourth aged men were consulted for marriage, land and property matters; 20percent aged men participated as leader or adviser for the societal work; 83.23percent consulted for the occupational matters and 36.6 percent aged men participated in social activities. Female's opinion was sought for social functions like marriage, festivals and ceremonies etc. However, their role as adviser is limited. Similar finding was also reported by Padma Mohanan et .al[28] in their study based on 600 elderly from Mangalore. The study reported that (7 percent) respondents' living with their sons and daughters had no share in decision making. Similarly, S. Kaur and M. Kaur[29]also observed that majority of senior citizens were enjoying authority in making familial decisions including education of children (65 percent); marriage (83.3 percent); household expenditure (75 percent); behaviour of children (81.67 percent); religious work (85 percent) and dealing with relatives(86.67percent) etc.

In addition, S.K. Ghosh and Maulik[30] in their study on identification of family authority in old age including 504 rural and 482 urban households depicted that variables e.g. education, death of spouse and age of respondent are all responsible for having decision making power in old age . Their findings clearly reveal this fact as 82.44percent urban and 73.14percent rural aged were retaining authority in the family up to the age of 64 years only. Moreover, with the death of spouse only 26.4percent rural and 42.1percent urban respondents were able to retain their family authority.

3.15: Distribution of respondents according to their social status

Social status determines an individuals' position within the family. For senior citizens this variable plays a significant role as it not only affects their social position but also determines their mental and psychological health.

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27 Jain, M. and Sharma, A. (2004). *Significance of productive engagement in work on perceived Death Anxiety*. In Help Age India. Research and Development. Vol. 10. No.1. May Issue. p.29.

28 Mohanan, P. and Sajjan, B.S.(2005). *Problems of the aged: a multi dimensional approach*. In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR- IFCU. Project Report on Ageing and Development. pp.149-150.

29 Kaur, S. and Kaur, M. (1987). *Psychological Problems of the Aged*. In Dak, T.M. and Sharma, M.L. (Ed.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.76.

30 Ghosh, S.K. and Maulik. (2006). *Family Authority in Old age*. In Help Age India Research and Development. Vol. 12. No.3. p. 26.

Table 3.15: Distribution of respondents according to their social status

S. No	Social status	No of Respondents	Percentage (in percent)
1	Decline	173	34.6
2	Remain Similar	276	55.2
3	Enhance	51	10.2
	Total	**500**	**100.0**

The above table clearly indicates that a good majority of respondents (55.2 percent) were sharing the similar social position within their family as they earlier used to get. However, almost one-third of the respondents (34.6 percent) reported that they had not been given the same respect as they earlier used to receive. This is because of their poor health and dependency for financial matters. Moreover, they generally belong to old-old and oldest old age group. However, a very small percentage (10.2 percent) reported that their social status had enhanced in old age. They were mostly from higher income groups. Due to possession of financial assets their family members give due respect to them and consider all their requirements. Thus to enjoy healthy ageing, possession of assets is must.

3.16: Relationship between Social status and Gender

There is found a significant relation between social status and gender as the table indicates the Chi-square value for present table as greater than the actual value at 0.05 level of significance (23.441 > 5.991).

Table 3.16: Relationship between Social status and Gender

S. No	Social Status	Gender		Total
		Female	Male	
1	Decline	108 (43.72 %)	65 (25.69 %)	173 (34.60 %)
2	Remain similar	125 (50.60%)	151 (59.68 %)	276 (55.20 %)
3	Enhanced	14 (5.66 %)	37 (14.62 %)	51 (10.2 %)
	Total	**247**	**253**	**500**

The Table 3.16 clearly reveals that females are more vulnerable than males in terms of their social status as 108 female respondents (43.72 percent) reported that their social status has declined in old age, whereas only 65 male respondents (25.69 percent) reported of having declined social status. Similarly, 125 female respondents (50.60 percent) reported that there is no impact of old age on their social status as all of them were sharing the same social position and roles within the family which they earlier used to share. However, only 14 female respondents (5.66 percent) reported that their social status increases with age and they have been given more weight age in the family decisions as per their experiences. In case of male respondents, the corresponding population was 151 for sharing similar status (59.68 percent) and 37 for getting enhanced status (14.62 percent) which clearly indicates that males are still enjoying better position in terms of social status as compared to their female counterparts in old age.

3.17: Relationship between Social status and Age of respondents

There is found a significant relation between social status and age of respondents as the table indicates the Chi-square value for present table as greater than the actual value at 0.05 level of significance (17.325 > 7.82).

Table 3.17: Relationship between Social status and Age of Respondents

S. No	Social Status	Age of Respondents (in yrs.)			Total
		60-70	70-80	80 +	
1	Decline	76 (28.14%)	70 (42.68%)	27 (40.90%)	173 (34.60%)
2	Remain similar	156 (57.77%)	83 (50.60%)	37 (56.06%)	276 (55.20%)
3	Enhanced	38 (14.07%)	11 (6.70 %)	2 (3.03%)	51 (10.20%)
	Total	**270**	**164**	**66**	**500**

The above table clearly reveals that with the onset of old age; the respondents generally observed decline in their social status. Further, on looking into the

advancement of age within the different age brackets; it was found that the majority of respondents belonging to the 'young-old' age group 156 (57.77 percent) considered their social status as similar as the earlier years of their life. This was followed by decline in social status as noticed by 76 respondents (28.1 percent). However, a significant number of respondents reported increase in their social status (14.07 percent) within their family. Similarly, majority of old-old (50.60 percent) and oldest-old (56.06%) respondents thought that they were sharing the similar status within their family as they earlier used to share. The reason being the prevalence of joint family system and the follow up of traditional practices of giving love and respect to their parents. However, very few respondents from old-old (6.70 percent) and oldest-old age group (3.03 percent) experienced enhancement in their social position. Those who experienced enhanced social status were generally from higher income group and had achieved many positive qualities in life. This shows that although there is a decline in social status of the respondents with age, but due to higher education and strong social ties, many of the senior citizens of Aligarh are still enjoying better social status.

3.18: Relationship between Decision Making and Gender

There is found a significant relationship between decision making power and gender as the calculated value of chi-square (12.403) comes out to be greater than the tabled value (3.841) at 0.05 percent level of significance.

Table 3.18: Relationship between Decision Making and Gender

S. No	Decision Making	Gender		Total
		F	M	
1	No	143 (57.89 %)	93 (36.75 %)	236 (47.2 %)
2	Yes	104 (42.10 %)	160 (63.24 %)	264 (52.8%)
	Total	**247**	**253**	**500**

The table 3.18 shows that in most of the cases females are not involved in decision making as 143 female respondents reported that they were not given any chance in deciding their family and other issues. In addition, females (104) who have reported

their involvement in decision-making also complaint of having partial share i.e. they got involved in the discussion part without giving any choice to alter or take the final decision.

In present study, a large majority of males 160 respondents(63.24percent) reported to have full share in decision-making as compared to their female counterparts 104 (42.10 percent). The present finding therefore shows that the actual decision makers were the male either as a husband, brother or a son.

3.19: Relationship between Decision Making and Age of Respondents

There is found a significant relationship between decision making power and age of respondents as the calculated value of chi-square (16.715) comes out to be greater than the tabled value (5.9) at 0.05 percent level of significance. The table shows that in oldest-old age group , most of the cases include denial of decision making power (66 percent).Similar is the problem with the old-old age group where denial was experienced by 84 respondents (51.21 percent).This denial was experienced due to their poor health and sometimes due to financial dependency. However, the majority of young-old (60 percent) were having full share in decision making of all the family decisions. This pattern clearly shows the vulnerability of senior citizens towards rising age.

Table 3.19: Relationship between Decision Making and Age of Respondents

S. No	Decision Making	Age of respondents (in yrs.)			Total
		60-70	70-80	80+	
1	No	108 (40.00%)	84 (51.21%)	44 (66.66 %)	236 (47.20%)
2	Yes	162 (60.00%)	80 (48.78%)	22 (33.33 %)	264 (52.80%)
	Total	**270**	**164**	**66**	**500**

3.20: Distribution of respondents on the basis of their Abuse

Abuse incorporates financial abuse, emotional abuse, sexual abuse and neglect along with physical abuse. Elder abuse is something which is more prominent but least

reported. In every household the senior citizens undergo abuse of one kind or the other. Considering abuse as a sign of disrespect and decline in social position within the society, the senior citizens hesitate to report. The more severe the form of abuse, the least reported the case would be. The vulnerability towards the abuse increases with age, as respondents belonging to oldest-old age category reported to experience more abuse as compared to the young-old and the old-old age groups. This is due to their physical and financial dependence. In present study, the majority of senior citizens 350 (70 percent) belonging to old-old and the oldest-old age category denied to have any form of abuse within the family and society. Out of remaining, 17.2 percent reported the incidence of verbal abuse, 7.6 percent reported emotional abuse and neglect, whereas, a very small percentage of respondents 26 (5.2 percent) reported the case of physical abuse.

Similar findings have been reported by U. Bambawale[31] in her study based on 864 elderly women of Pune. She reported that elderly women undergo social abuse (non inclusion in activities of other generation, through silence in the house, keeping secrets for certain occasion, not taking aged when going outside etc.) in 36.12 percent of the cases, financial abuse (economic dependency and deprivation) was however, experienced in 12 percent cases, legal abuse in 5.5 percent cases and religious abuse in 5.5 percent cases respectively. However, 40 percent women felt total neglect by the family members.

Table 3.20: Distribution of respondents on the basis of their Abuse

S. No	Type of abuse	No of Respondents	Percentage (in percent)
1	Verbal	86	17.2
2	Physical	26	5.2
3	Emotional and Neglect	38	7.6
4	Not applicable	350	70.0
	Total	**500**	**100.0**

31 Bambawale, U. and Streevan. (1996). *Abuse of the Aged.* In Kumar, V. (Ed.). Ageing: India Perspectives and Global Scenario. Proceedings of the International Symposium Gerontology and Seventh Conference of the Association of Gerontology, India. p.301.

Similarly, A.M. Khan[32] while focusing on medical care across three different Socio-Cultural Groups in Delhi observed that 70 percent of the respondents were suffering from mild, 9.5 percent from moderate and 9.2 percent from severe form of neglect and indifference. Similarly, 48.9 percent undergoes mild, 17.2 percent moderate and 9.7 percent from severe form of indifference in medical care, whereas, 39.2 percent senior citizens are affected by mild, 31.8 percent by moderate and 8.3 percent by severe form of financial abuse. This was also followed by 79.1 percent mild, 12.7 percent moderate and 1.9 percent cases of severe emotional abuse. R.K. Punia et.al[33]on comparing aging problems among rural-urban areas also observed the cases of abuse present in both the communities but with a slight difference. They noticed that the rural aged were subjected to more physical assault than the urban aged as manhandling by the family members was reported by 7.82 percent rural elderly as compared to the urban elderly i.e. 3percent only. Shubha Soneja[34] in her country report for WHO also found lack of emotional support, neglect by the family members, feeling of insecurity, loss of dignity, maltreatment and disrespect by the family as the common forms of abuse experienced by the elderly but not a single elderly person recognized them as abuse and they all linked abuse to only severe acts of violence. Similar is the findings of A. K. Panda[35] in M.P. including two-third rural and one fourth urban respondents where 0.5 percent were forced to work in kitchen, 24 percent were forced to sleep in the balcony or out yard, 11.3 percent received the rude behavior of the family members, 87.3 percent were totally ignored or neglected, 5.4 percent denied food, 5.4 percent verbally abused, 1.2 percent slapped, 0.6 percent thrown out of house. Hence, from above findings; it can be concluded that elder abuse is very serious phenomenon of present families which needs serious initiatives for its management.

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32 Khan, A. M. (2005). *Empowerment of elderly-Source of healthy Ageing*. In Indira, J. P. (Ed.). Ageing in India: Retrospects and Prospects. CCR-IFCU. Project Report on Ageing and Development. p.142.

33 Punia, R.K. and Malik, et.al.(1987). *Aging Problems: A study of Rural- Urban Differentials*. In Dak, T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. pp.56-63.

34 Soneja, S. *Elder Abuse in India; Country Report for World Health Organization*. Help Age India. C-14, Qutab Institutional Area. New Delhi-110016. p.4.

35 Panda, A.K. (2008). *Elderly Women in Madhya Pradesh: Condition and Challenges*. In Help Age India. RandD Journal. Vol.14. No.2 May. 2008.

3.21: Distribution of respondents on the basis of Frequent Abuser

In case of elderly people, the frequent abusers are their family members in general and siblings in particular. The present study also indicates that out of the total number of reported cases of abuse of any kind (150), a large number of primary abusers were their son (56 percent) followed by daughter-in-laws (29.34 percent), spouse (7.34 percent) and daughter (0.66 percent).This shows that daughters shared more healthy relations with their parents as compared to their male counterparts. Those who complained their spouse as abusers were generally females and belong to the lower income group. They were un-educated and dependent which makes them easy targets. It was further reported that the role of outsiders in abusing the elderly was very small i.e. 2.66 percent only. The outsiders abused the senior citizens in cases of dacoit and theft only and no case of verbal abuse by the community people against the senior citizens was reported. This is because in Aligarh, majority of the respondents were living in joint families and hold good contacts with the neighbours so the chances of outsiders to abuse them were limited.

Table 3.21: Distribution of respondents on the basis of Frequent Abuser

S. No	Frequent Abuser	No of Respondents	Percentage (in percent)
1	Spouse	11	7.34
2	Son	84	56.00
3	Daughter	01	0.66
4	Daughter-in-law	44	29.34
5	Relative	06	4.00
6	Outsiders	04	2.66
	Total	**150**	**100**

Thus from above findings, it can be concluded that the elderly people were getting abused in their own houses.

3.22: Reporting of abuse by the respondents

Abuse was found to be the most rampant phenomena but its reporting in a formal manner was almost negligible. Many of the senior citizens remained silent on the issue of abuse. This may be due to fear of humiliation or fear of losing self respect.

The Table 3.22 also indicates that almost two-third of the respondents did not reply on the question of getting abused at home or outside the family. Similarly, there were seventy respondents (14 percent) who acknowledge one or the other form of abuse in their daily living but had never reported to any one, not even to their spouse. Out of the remaining, 28 respondents (5.6 percent) felt free to discuss the incidences of abuse with their friends, 5.0 percent discussed it openly with their spouse, 3.0 percent with neighbours, 1.8 percent with family members and very few (0.6 percent) discussed it with their relatives.

Table 3.22: Reporting of abuse by the respondents

S. No	Reporting Person	No of Respondents	Percentage (in percent)
1	Spouse	25	5.00
2	Family members(son /daughter)	09	1.80
3	Friends	28	5.60
4	Neighbours	15	3.00
5	Relatives	03	0.60
6	No one	70	14.00
7	Not Applicable	350	70.00
	Total	**500**	**100.00**

The reasons of non-reporting of the cases of elder abuse were the maintenance of family honour, self-respect and financial dependence. Many respondents do complained that reporting is of no significance unless the abuser had been punished by the society. Instead, they worried that formal reporting of elder abuse will enhanced their family conflicts. This observation is fully supported by the findings of A.M. Khan[36] who undertook their study in Delhi. The findings suggests that non-reporting of the cases of elder abuse was held in 56 percent of the cases, whereas, reporting took place only in 44 percent of the cases. The reason they had given for non- reporting of the cases of abuse were the feeling that it was totally a personal matter and would stop on its own. However, out of 44 percent reporting cases of elder abuse; 6.4 percent reported it to their relatives; 10.7 percent to neighbours, 19.3 percent reached to police and 7.6 percent were in favour of taking help from some

36 Khan, A. M. (2005). *Empowerment of elderly-Source of healthy Ageing.* In Indira, J.P. (Ed.). Ageing in India: Retrospects and Prospects. CCR-IFCU. Project Report on Ageing and Development.pp.131 and 133.

agencies and NGOs. Thus from above findings, it can be concluded that elder abuse is still considered as a kind of social stigma amongst the elder generation.

3.23: Coping against disrespect and loss of self-esteem

In old age the feeling of disrespect and loss of self-esteem is very common. Feeling of disrespect is generally associated with loss of social status, loss of authority and decision making power. On getting disrespect from family; the elder people started to live in isolation and hence they lost their self-esteem. To cope up with the feeling of disrespect and lack of self-esteem, they adopted a range of different coping responses. For sake of simplicity, these responses have been classified into two categories namely, Emotion Focused coping and Problem Focused Coping.

Emotion Focused Coping includes the strategies like Keeping oneself busy to take one's mind off the issue, letting off steam to other people, praying for guidance and strength, ignoring the problem in the hope that it will go away, distracting self (e.g. TV, eating), building oneself up to expect the worse and getting isolated etc. Problem Focused Coping involves dealing up of the problem by discussing it with family, doing things like active and planned problem-solving, seeking specific assistance from others to work on changes (such as information, financial support, or expertise) and asserting opinions to feel more empowered etc. The findings revealed that majority of respondents 379 (75.8 percent) adopted for Emotion Focused Coping. The Problem Focused Coping was found to be the choice of only one-fourth of the respondents (24.2 percent). The findings also revealed that the respondents in the age group of 70 to 80 years and 80 plus used to follow Emotion Focused Coping whereas Problem Focused Coping was adopted by the Young-Olds (60-70 years).

Table 3.23: Coping against disrespect and loss of self-esteem

S. No	Coping Pattern	No of Respondents	Percentage (in percent)
1	Emotion Focused Coping	379	75.8
2	Problem Focused Coping	121	24.2
	Total	**500**	**100.0**

In regard to healthy life style; E.Gunnarsson [37]in his study carried out in Sweden and exclusively on the elderly belonging to 'oldest-old' age group reported that both men and women respondents pointed out the importance of being active; positive thinker, remaining stress free i.e.to keep busy throughout the day, and not good to take things easier as some of the qualities required in maintaining self-esteem.

Similarly, Susan L. Hutchinson et.al[38] in their study clearly reported that joining a Red Hat Society serve as a coping resource to them as it provides social support, emotional regulation, sustaining coping efforts and Meaning focused coping. 17 out of 65 reported that society not only provides them with chance to have a break and recharge, but also gave them something to look forward. This shows that problems associated with self-esteem can be easily coped up by following problem focused coping practices.

3.24: Relationship between Coping Strategies and Age of respondent

The present study indicates a significant relationship between the coping practices adopted by the respondents and the age of respondents as the chi value comes out to be 17.325 which is greater than the actual value at 0.05 level of significance. The findings revealed that majority of respondents 379 (75.8 percent) adopted for Emotion Focused Coping. The Problem Focused Coping was found to be the choice of only one-fourth of the respondents (24.2 percent).

Table 3.24: Relationship between Coping Strategies and Age of respondent

S. No	Coping Strategies	Age of respondent (in years)			Total
		60-70	70-80	above 80	
1	Emotion focused coping	202 (73.72%)	120 (75%)	57 (86.36%)	379 (75.8%)
2	Problem focused coping	72 (26.27%)	40 (25%)	9 (13.63%)	121 (24.2%)
	Total	**274 (100%)**	**160 (100%)**	**66 (100%)**	**500 (100%)**

37 Gunnarsson, Evy. (2009). *I think I have had a good life: the everyday lives of older women and men from a life course perspective.* In journal Ageing and Society: Cambridge University Press. Vol.29, No.1,Jan. p. 41.

38 Susan L. H. Careen M.Y., Staffordson, J. And Deborah, L. K. (2008). *Beyond fun and friendship: the Red Hat Society as a coping resource for older women.* Ageing and Society. pp 979-999.

The age-wise distribution of respondents on the basis of their coping strategies denotes that emotion focused coping has been followed by majority of respondents (73.72 percent) in the age group of 60 to 70 years followed by the respondents belonging to the age group of 70 to 80 years (75 percent) and above 80 age group (86.36 percent) respectively.

The findings also revealed that the problem focused coping has been showing decreasing trend as 26.27 percent respondents from the age group of 60 to 70 years, followed by 25 percent from 70 to 80 age group and 13.63 percent in above 80 years of age group used to follow the problem focused coping. This pattern clearly shows that with advancement of age; the capacity to solve any problem decreases and hence they adopted the easier way to come out of this in terms of emotion focused coping.

3.25 Perception regarding living in Old Age Home.

In Indian society, Old age homes are still considered as a symbol of isolation, neglect and deprivation. Living with family was always put as the first choice by the aged. This is due to the prevalence of joint family system. In the present study researcher made an attempt to know whether the respondents like old age homes or they develop negative attitude towards them. What was their perception regarding the living of dependent elderly in old age homes? Do they think that some other alternative may work effectively rather than providing old age homes to senior citizens? The above questions were asked to all the respondents and it was found that majority of respondents 413 (82.60 percent) were in a favour of sending the dependent and frail elderly people to old age homes irrespective of age.

Table 3.25: Perception regarding living of dependent elderly in Old Age Home

S. No	Response	No of Respondents	Percentage (percent)
1	Yes	413	82.60
2	No	85	17.00
3	No response	02	0.40
	Total	**500**	**100.0**

This shows that majority of senior citizens realizes that aged had their own self-respect along with their personal needs and if both these needs were not fulfilling

within the premise of a family; then they must shift to old age homes. However, 85 respondents (17 percent) replied with saying "NO" to old age homes. Those who said 'NO' were of the opinion that instead of keeping the senior citizens separated from their family and friends, government should provide some financial assistance to them. However, the old age pension is providing relief to some extent but it is not available to all. A very small percentage (0.40 percent) did not respond as they had no idea of living in old age homes and their functioning.

3.26: Respondents self-preference to Old Age Home over present living

In contrast to above findings, the question whether the respondent themselves want to shift in any old age home or not has been asked. In response to this, a large majority of respondents (93.80 percent) denied for living in old age homes even if offered free of cost, whereas, a very small number of respondents (5.8 percent) gave their consent for staying in old age homes. Further, only two respondents (0.4 percent) were unaware of the provision of old age homes. Those who preferred living in old age home over their present living arrangement were all belonging to the lower income group (up to 1000). They had no one in the family to take care of them and were frequently abused verbally and physically by their children and relatives. Those who preferred living in their own home were financially sound and admitted that home is the best place to live in.

Table 3.26: Respondent's self-preference to old age home over present living

S. No	Preference	No of Respondents	Percentage (in percent)
1	Prefer	29	5.80
2	Don't prefer	469	93.80
3	No response	02	0.40
	Total	**500**	**100.0**

The above finding clearly shows that in India, family plays a significant role in the life of senior citizens. During the life course, senior citizens had developed an emotional attachment with their family. As a result, they did not want to leave their home even if they were getting abused or facing any kind of difficulty. Thus from

above findings it can be easily concluded that in India, family ties are very important. Senior citizens are taken care by the family and they themselves prefer to live with them rather than shifting to any old age home.

3.27: Leisure Time Activities followed by the respondents

Leisure time is the time available for ease and relaxation. In old age, the senior citizens had a plenty of spare time and spending that in a favourable manner is a challenge for senior citizens. The Table 3.27 attempts to explore the various leisure time activities of the senior citizens.

Table 3.27: Leisure Time activities followed by the respondents

S.No	Leisure Time Activity	No of Respondents	Percentage (percent)
1	Participation in Social or political events	56	11.2
2	Pursuing religious cults	179	35.8
3	Visiting public places	124	24.8
4	Doing household jobs	166	33.2
5	Reading (magazines, books etc.)	82	16.4
6	Playing (indoor/outdoor games)	68	13.6
7	Watching T.V./ listening radio	275	55.0
8	Grand parenting	108	21.6
9	Gossiping	323	64.6
10	Any other (Gardening, joining senior citizens club etc.)	42	8.4

(Miscellaneous responses)

The table depicts that majority of respondents, 323 (64.6 percent) used to spend their leisure time in gossiping with peers. However, 275 (55.0 percent) respondents were in a habit of watching T.V. / listening radio, Pursuing religious cults 179 (35.8 percent), doing household jobs 166 (33.2 percent), visiting public places 124 (24.8 percent) and grand parenting 108 (21.6 percent) respondents. However, very few respondents 42 (8.4 percent) showed their interest in other activities including gardening, joining senior citizens club, participation in social and political events of society 56 (11.2 percent)respondents etc. The findings also revealed that respondents belonging to

middle and higher income group use to follow playing 68 respondents (13.6 percent) and reading 82 respondents (16.4 percent) as their favourite pass time.

In this regard, A. Singh, T. M. Dak and M.C. Sharma[39]while studying the leisure time activities of elderly males observed that playing of cards (42 percent) was the favourite time pass of senior citizens followed by gossiping (19 percent); solitude (10 percent); smoking huqqa (6 percent); working in field (7 percent); telling stories, playing tonga (1 percent); tending animals (3 percent) etc.

R.K. Punia et.al[40]in another study compared the leisure time activities of urban aged with that of their rural counterparts and found that the rural aged are relatively more engaged in farming (31.3 percent) and livestock (31.3 percent.),whereas, the urban aged are engaged more in looking after the children at home (35.38 percent),economic activity at farm or business establishment (24.62 percent), household chores (16.92 percent), looking after the animals (7.69 percent) and attending community meetings (6.15 percent) etc.

Following similar pattern, M.S. Randhwa[41] identified the differences in leisure time activities as rest and sleep (88 percent rural, 87 percent urban); walking (62 percent rural, 70 percent urban); gardening (27 percent rural, 31 percent urban); yoga or jogging (13 percent rural, 13 percent urban); watching games (60 percent rural, 20 percent urban); went for pleasure trip (7 percent rural, 16 percent urban); playing indoor games (12 percent rural, 34; percent urban); listening radio (78 percent rural, 60 percent urban); watching T.V.(24 percent rural, 78 percent urban); reading (18 percent rural, 75 percent urban); gossiping (82 percent rural, 57 percent urban); visiting friends and relatives (26.6 percent rural, 81.6 percent urban); participation in religious activities (88 percent rural, 87 percent urban); political activities (9 percent rural, 10 percent urban); social service activities (8 percent rural, 26 percent urban); visiting clubs (11 percent urban) and visiting public parks (37 percent urban) etc.

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39 Dak, T.M. and Sharma, M.C. et. al. (1987). *Work and Leisure among the Aged Male.* In Dak, T.M and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.87.

40 R.K. Punia and Malik et .al. (1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak, T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. pp.56-63.

41 Randhwa, M.S. (1991). *The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.3.

S. Kaur and M. Kaur[42] reported smoking of Huqqa (13.33 percent); playing cards (15 percent); gossiping (15 percent); religious activities (5 percent); looking after children (1.67 percent) as the major activities of leisure among the senior citizens.

Similarly, N. Prabhavaty Devi and P.J. Murgsen[43] compared the leisure time activities of the institutionalized and non-institutionalized elderly. The findings reveal that those who are living in Old age homes are more engaged in reading (44 percent M, 31 percent F), Gossiping (17 percent M, 26 percent F), Listening to Radio (7 percent M,7 percent F), Watching TV(25percentM, 26 percent F) and doing religious task (7 percent M,10 percent F). However, those who are residing in their own homes are engaged more in gossiping (35 percent M, 29 percent F), reading (24 percent M, 28 percent F), watching TV (24 percent M, 22 percent F), listening radio (3 percent M, 2 percent F), doing religious task (3 percent M, 5 percent F) and doing nothing (11percent M, 14percent F). Hence, in total, reading (31percent) came out to be their favourite leisure time activity followed by gossiping (27 percent), listening Radio (5 percent), watching T.V (24 percent), others (religious task; 6 percent) and doing nothing (7 percent).

Evy. Gunnarsson[44]also noticed the leisure time activities of oldest-old age group in Sweden and listed them as doing houschold tasks, reading books and magazines, watching T.V., using the computer and gardening; joining study circles, playing bridge, meeting friends; talking on phones; and taking part in club activities. This shows that the leisure time activities are more or less similar in senior citizens of all areas and age group.

3.28: Satisfaction with Leisure Time Activities

It was generally found that the plenty of spare time which the senior citizens had in their old age was not properly utilized. The reasons behind the improper utilization of leisure time include lack of facilities, improper channels of communications, physical

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42 Kaur, S. and Kaur, Ma. (1987). *Psychological Problems of the Aged.* In Dak, T.M. and Sharma, M.L. (Ed.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p.76.

43 Prabhavathy, D. and Murgsen, P.J. (2007). *Socio-Economic profile of the institutionalized elderly.* In Prakash, I. J. Aging: Strategies for an active old age. Vol. 7. Aging and Development Project. CCR-IFCU Publications. p.54.

44 Gunnarsson, Evy. (2009). *I think I have had a good life: the everyday lives of older women and men from a life course perspective.* In journal Ageing and Society: Cambridge University Press. Vol. 29. No.1. Jan. Issue. p.41.

and financial dependence etc. Hence, a question was asked to diagnose the level of satisfaction with their leisure activities as shown in table 3.28.

Table 3.28; Satisfaction with Leisure Time Activities

S.No	Level of Satisfaction	No of Respondents	Percentage (in percent)
1	Fully Satisfied	132	26.4
2	Partially Satisfied	249	49.8
3	Not satisfied	119	23.8
	Total	**500**	**100.0**

Leisure Time Activities in which the senior citizens were involved were generally based on their forced choices instead of freedom to select their favourable spare time. Hence, they were either partially satisfied or totally dissatisfied with the nature of activities which they used to perform. The Table 3.28 also indicates that almost half of the respondents 249 (49.8 percent) were partially satisfied with their leisure time activities, whereas 119 (23.8percent) respondents were not satisfied. However, 132 respondents (26.4 percent) were fully satisfied with their leisure time activities. Those who were fully satisfied were generally from higher income group, males and belong to the young-old age category. Thus from above findings it can be inferred that the majority of respondents were not having facilities to choose their preferred life style.

3.29: Role of Media in reducing Intergenerational Gap

Media plays an important role in giving direction to the society and especially to the young minds. Today every individual is connected with media either via electronic medium, printed medium or both. Keeping this in mind, the researcher investigated the role of media in reducing the intergenerational gap between the aged and the younger generation. The findings revealed that media is totally responsible for enhancing the generational gap as 179 (35.8 percent) of the respondents reported the problem of intergenerational gap.

Table 3.29: Role of Media in reducing Intergenerational Gap

S. No	Respondents' view	No of Respondents	Percentage (in percent)
1	Reduces gap	44	8.8
2	Enhances gap	179	35.8
3	Depends on individual	100	20.0
4	No role to play	35	7.0
	Total	**500**	**100.0**

However, 100 (20.0 percent) respondents believed that gap depends on an individual and varies with time. It's a matter of acceptance that how one takes the things. On the other hand, there were 35 (7.0 percent) respondents who believed that media has no role in enhancing or reducing the intergenerational gap. For remaining 142 (28.4 percent) respondents, the question was not applicable as they don't have frequent access to any form of media. Besides, they were illiterate and physically dependent. They were also belonging to the 'oldest-old' age category. This shows that media as such is not focusing on the issues related to elderly, especially societal and emotional needs.

3.30: Frequency of using religion as a means of coping against distress

Since time immemorial, religion has been used as an important coping mechanism against psychological and emotional problems. People still have a deep faith in God and religion and many even opted for religious and spiritual activities as a means of coping against distress. Table 3.30 indicates that out of 500 respondents, almost half of the respondents 229 (45.8 percent) were using religion as a means of coping against psychological and emotional problems, whereas, 144 (28.8 percent) respondents reported to follow it sometimes. However, remaining one-fourth (25.4 percent) of the respondents were not in a habit of adopting religion as a means of coping. This shows that religion comprises a significant role in coping with difficult life-situations especially at the time of distress and psychological and emotional problems. It was also found that females were more involved in religious practices as compared to their male counterparts.

Table 3.30: Frequency of using religion as a means of coping against distress

S. No	Use of religion as a means of coping	No of Respondents	Percentage (in percent)
1	Always	229	45.8
2	Sometimes	144	28.8
3	Never	127	25.4
	Total	**500**	**100.0**

In this regard, P.K. Muttagi[45] also identified the practice of religion asa common trend among the aged men and women on a regular basis. He further reported that the senior citizens were using religion as a weapon against the management of psychological stress, alienation and loneliness.

3.31 Distribution according to the availability of basic services at home.

Life is full of necessities. Some needs are basic whereas others are based on individuals' own desires. No one can think of a life without fulfillment of basic requirements. In old age when body started showing decline in almost all aspects e.g. physical, mental and biological; the life becomes almost difficult. In a situation like this, when deprivation to basic necessities was added, the life becomes totally miserable. Hence, the variable 'availability of basic services' has been introduced in the present study to check their access to basic services. Besides, the basic services at their door step will help senior citizens in making their life smoother and better. It also put them up in the ladder of socio-economic status. The above table indicates that almost half of the respondents 252 (50.4 percent) had personnel toilets, whereas, half of them were using public toilets. Similarly, 407 respondents (81.4 percent) had bathroom inside their houses, whereas, remaining 93 (18.6 percent) were using public bathrooms.

The Table 3.31 also highlighted a hard core fact that 180 respondents (36 percent) were not having access to even safe drinking water. They used to fill water from outside. Moreover, Communication facility was available to 316 respondents (63.2 percent), recreation facility was available to 358 respondents (46.2 percent) and personal transport was available to almost half of the respondents (51.8 percent).

45 Muttagi, P.K. (1997). *Ageing issues and Old age care: A Global Perspective*. New Delhi: Classical Publishing Company. p.41.

Hence, from the above findings it can be concluded that almost half of the respondents were deprived of even the basic services in their old age.

Table 3.31: Distribution according to the availability of basic services at home

S. No	Facility available at home	Availability to Respondents	
		Available	**Unavailable**
1	Toilet facility	248 (49.6 %)	252 (50.4 %)
2	Bathing facility	407 (81.4 %)	93 (18.6 %)
3	Water facility (hand pump/ pipeline etc.)	320 (64.0 %)	180 (36.0 %)
4	Communication (Telephone, internet etc.)	316 (63.2 %)	184 (36.8 %)
5	Transport (Car, scooter, bicycle)	259 (51.8 %)	241 (48.2 %)
6	Recreation facility (T.V., Radio etc.)	358 (46.2 %)	142 (28.4 %)

(Miscellaneous responses)

3.32: Distribution according to the primary source of income or occupation

As regards the occupation of respondents, it was observed that 27.2 percent belongs to service class families and were getting pension, 18.4 percent belongs to labour class and another 10.6 percent were from business class families. It was also observed that very few respondents (3.4 percent) in the young-old age group were still working in private jobs. In addition, 11.2 percent had their agricultural lands and cattle at native place, 6 percent were getting rent out of their houses, 6.8 percent were dependent on interest coming out of fixed deposits and only one percent was receiving old age and widow pensions. Remaining respondents (15.4 percent) were dependent on family and friends for their financial requirements. The underlying reason being their poor health and physical dependence.

In regard to the above findings, R. Bakshi et.al[46] in their study based on 120 respondents from Ludhiana City of Punjab including aged living in old age homes and aged living in their own house reported that those who are living in their own homes were mostly belonging to business class families (41.6 percent) followed by service

46 Bakshi. R, et. al. (2007). *Problems of the Aged living with families and in senior citizens homes: A comparative study.* In Indira J.P. (Ed.).Aging strategies for an active old age. 7th volume of the Aging and Development Project. CCR-IFCU Publications. p.68.

class (40 percent) and other occupational activities (18.4 percent). Out of those living in Old Age Homes; 50 percent were belonging to service class, 23.3 percent to labor class and 18.3 percent to business class respectively.

Table 3.32: Distribution according to the primary source of income or occupation

S. No	Primary Source of income / occupation	No of Respondents	Percentage (in percent)
1	Retirement Pension	136	27.2
2	Old age pension/ Widow pension	5	1.0
3	Interest out of savings	34	6.8
4	Rent from houses	30	6.0
5	Monthly/ Daily Wages	92	18.4
6	Salary from employment	17	3.4
7	Agriculture and related activities	56	11.2
8	Business	53	10.6
9	Not earning(Dependent)	77	15.4
	Total	**500**	**100.0**

In another study of similar kind, P. Mohanan and Sajjan B.S.[47] reveals that irrespective of living status, majority (71 percent living in family and 63 percent living in old age homes) had no income of their own and hence they were totally depending on others for their financial requirements. However, very few had some source of income including salary from job, family business, pension, and support from children and relatives and through interest coming out of fixed deposits.

The findings of M. Jain and A. Sharma[48] related 'productive engagement' with 'death anxiety' and found that those who are having no source of income are more anxious to death. C.J. Thomas and F.T. Diengdoh[49] in their study on 231 elderly from seven districts of Meghalaya opines that in old age financial security plays a significant role as those who are earning less were facing serious problems. In another study, R.K.

47 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi dimensional approach.* In Prakash, I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing And Development. p.118.

48 Jain, M. and Sharma, A. (2004). *Significance of productive engagement in work on perceived Death Anxiety.* In Help Age India Research and Development. Vol. 10. No.1. May Issue. p.19

49 Thomas, C. J., and Diengdoh, F. T. (2010). *Ageing in Meghalaya.* New Delhi: Akansha Publishing House. Vol. 6.p. 206.

Punia et.al.[50] correlated occupation with the nature of community. The findings highlighted 'farming' as the primary occupation of the rural elderly, followed by service (26.95 percent), part-time job (6.08 percent) and business (5.21 percent). However, in urban areas; 70.76 percent were found to be engaged in service sector followed by farming related activities (9.23 percent), part-time job (23.07 percent) and business (20 percent). Further, 44.61percent urban and 23.47 percent rural respondents had no income of their own.

L. S. Talunkdarand John A. Menachery[51] observes that in rural areas 77.1 percent were gainfully engaged in some work, whereas, 23.9 percent are not doing any kind of job. Out of working elderly, 66.6 percent were agricultural labourer, 22.2 percent were farmers and remaining 3.7 percent were in non-agricultural services. The above findings therefore suggest that more number of rural elderly continues to work even in their old age as compared to the elderly living in urban areas. Hence, the financial situation of aged living in villages is better than aged residing in cities.

3.33: Distribution according to monthly income of respondents

The monthly income is an important variable to check one's social status and quality of life. Table 3.33 shows that the monthly income of 112 respondents (22.4 percent) was below Rs.1,000, followed by 82 respondents (16.4 percent) earning between Rs.1000 and Rs.5000 per month respectively i.e. considered as 'low' in the present study. There were in total, 194 such respondents (38.8 percent) belonging to lower income group. However, 106 respondents (21.2 percent) and 161 respondents (32.2 percent) were getting their income in the range of 5,000 to 10,000 and between Rs,10,000 to 20,000 respectively and are put in the category of 'moderate' income. However, the remaining 39 respondents (7.8 percent) belongs to the high income group as getting Rs.20,000 and above on the monthly basis . Out of these, many (11) reported that their monthly income was even more than Rupees one lakh. They had their own business, properties, pension and savings. They were also highly educated.

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50 Punia,, R.K et.al. (1987). *aging problems: a study of rural-urban differentials*. In Dak, T.M and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi. Ajanta Publications. p. 57.

51 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro- level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280-284

Thus in total (61.2 percent) of the respondents were getting sufficient income to fulfill their basic needs. The present findings were in agreement to the findings of P.K. Goel [52]who studied the socio-economic status of 350 elderly in rural area of Meerut and found that the majority (58.7 percent) belonging to economically well-off families followed by 38.2 percent respondents belonging to lower socio-economic status.

Table 3.33: Distribution according to monthly income of respondents

S. No	Monthly income	No of Respondents	Percentage (in percent)
1	up to 1,000	112	22.4
2	1,000 to 5000	82	16.4
3	5,000 to 10,000	106	21.2
4	10,000 to 20,000	161	32.2
5	20,000 and above	39	7.8
	Total	**500**	**100.0**

In addition, the respondents getting lower income (194 respondents) were found to get totally dependent on their siblings, relatives or friends for their financial needs. The reasons behind their economic dependence include poor health, low education and lack of employment opportunities. The findings of R. Bakshi et.al[53], Archana Kaushik Panda[54] and L.S. Tulankar and John A. Menachery[55]go in line with the present findings as in every study the majority of respondents were found to be dependent because of low earning. This shows that in old age financial stability is must.

3.34: Distribution according to the Ownership of financial assets

Keeping financial asset in old age is both-a boon and a curse. It is considered as a boon as it helps in maintaining the quality of life of senior citizens. It changes the

52 Goel, P.K. (2006). *Dietary Habit and nutritional status of the elderly in rural area.* In Help Age India Research and Development. Vol. 12. No.1. p. 5-30.

53 Bakshi. R, et. al. (2007). *Problems of the Aged living with families and in senior citizens homes: A comparative study.* In Indira J.P. (Ed.). Aging strategies for an active old age. 7th volume of the Aging and Development Project. CCR-IFCU Publications. p.68.

54 Panda, A.K. (2008). *Elderly Women in Madhya Pradesh: Condition and Challenges.* In HelpAge India. RandD Journal. Vol.14. No.2 May. 2008.

55 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro- level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp. 280-284.

attitude of family members towards them. Those who owe some financial asset are supposed to lead more satisfied life. The financial assets turn out to be a 'curse' when it became a cause for family conflicts and threat to social security. Daily many incidences of elderly deaths and robbery were highlighted in leading newspapers because of financial goods. In present study, financial asset signifies the ownership of property, agricultural land, household or flats, jwellery, heavy vehicles, savings in cash and animal resources etc.

Table 3.34: Distribution according to the Ownership of financial assets

S. No	Ownership of financial assets	No of Respondents	Percentage (in percent)
1	Low (No assets)	171	34.2
2	Moderate (having one)	193	38.6
3	High (above two)	136	27.2
	Total	**500**	**100.0**

The Table 3.34 indicates that a very small percentage (27.2 percent) of the respondents kept financial asset of good value with them, whereas, a large majority (38.6 percent) had either shifted it up to someone else or possess only household in which they were living. The remaining respondents 171(34.2 percent) did not hold any such asset. They were generally females and belong to lower income groups. Dr. N. Swarnalatha[56] also found that majority of respondents belonging to low income group (65.5 percent) were not in a position of holding any asset followed by 21 percent middle and 13.5percent high income groups holding some assets of good value. However, the observation of P.N. Sati[57]goes in contrast with the present findings as he reported that 95.7 percent of the respondents were holding some property in their old age.

L. S. Talunker and J. A. Menachery[58] also found that 74.3 percent of the respondents had not transferred their immovable property to anyone even in their old age.

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56 Swarnalatha, N. (2008). *Chapter: A study on health of aged women in rural areas of Chittoor district.* In HelpAge India, Research and Development Journal. Vol. 14. No.1. June Issue. P.20.

57 Sati, N. P. (1996). *Needs and Problems of Aged: A study for Social Intervention.* New Delhi: Himanshu Publication. p.210.

58 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro- level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological

Observation of A. K. Panda[59] also reported that 11 percent of the respondents were holding some property and 13 percent had jewellery of good value. A.M. Khan[60] also finds that 40.9 percent elderly having property on their own names, 31 percent on the name of their spouse and 11.2 percent on their son's name. This shows that transfer of property in old age is an individual's choice and there are many senior citizens who believe in keeping assets with them till the last walk of their life.

3.35: Relationship between Ownership of Financial Assets and Level of Education

In old age the ownership of financial assets generally decreases, but with education it keeps on increasing. The table 3.35 also reveals a significant relationship between ownership of financial assets and level of education as chi-square value comes out to be 18.02 which is more than the tabled value i.e. 9.48 at 0.05 level of significance.

Table 3.35: Relationship between Ownership of Financial Assets and level of education

S. No	Ownership of Financial Assets	Level of Education			Total
		Low	Moderate	High	
1	Low / Nil	155 (43.52 %)	10 (18.51 %)	6 (6.66 %)	171 (34.20%)
2	Moderate	139 (39.04 %)	23 (42.59 %)	31 (34.44 %)	193 (38.6%)
3	High	62 (17.2 %)	21 (38.88 %)	53 (58.88 %)	136 (27.2%)
	Total	**356**	**54**	**90**	**500**

The findings reveal that out of 500 respondents; 155 respondents (43.52 percent) were not holding any financial asset, and if so, it was their ancestral home only. Further, they all belongs to lower education group, whereas, only ten respondents (18.51 percent) from moderately educated group were having such possession. Similar is the

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Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp. 280-284.

59 Panda, A.K. (2008). *Elderly Women in Madhya Pradesh: Condition and Challenges.* In Help Age India, RandD Journal. Vol. 14. No.2 May. 2008.

60 Khan, A. M. (2005). *Empowerment of elderly-Source of healthy Ageing.* In Indira J.P. (Ed.). Ageing in India: Retrospect and Prospects. CCR-IFCU. Project Report on Ageing and Development. p.142.

case of highly educated group in which only 6 respondents (6.66 percent) were not holding any such asset. In addition, a large majority of respondents (58.88 percent) from highly educated group reported that they owe financial asset of high value.

Therefore, the present table clearly reflects that with increase in education, the ownership of financial asset increases. The reason behind this increase is the availability of high salaried jobs and occupation i.e. those having higher education will earn more and hence generate more financial assets.

3.36: Relationship between Financial Assets and Gender

After knowing the ownership of financial assets; the researcher made an attempt to diagnose the role of gender in holding the ownership of financial assets. In this regard, the present study (table 3.36) reveals a significant relationship in between ownership of financial assets and gender as chi-value comes out to be 18.19 which is more than the tabled value i.e. 5.99 at 0.05 level of significance. The findings highlighted the dominance of males over females in possession of financial assets as majority of females (42.91 percent) either do not hold any such asset, or if so, had ancestral home only which brings no money to them.

Table 3.36: Relationship between Financial Assets and Gender

S. No	Ownership of Financial Assets	Gender		Total
		Female	Male	
1	Low / Nil	106 (42.91 %)	65 (25.69 %)	171 (34.2 %)
2	Moderate	98 (39.67 %)	95 (37.54 %)	193 (38.6 %)
3	High	43 (17.40 %)	93 (36.75 %)	136 (27.2 %)
	Total	**247**	**253**	**500**

In contrast, a small number of male respondents (25.69 percent) reported to have low financial asset. A significant number of male respondents 95 (37.54 percent) reported that they owe moderate (having either one or two assets) level of financial assets, whereas, a few male respondents (36.75 percent) were holding high level of such

assets (three or more assets) of financial assets. The corresponding population for females was found to be 106 (42.91 percent) respondents holding low assets, 98 (39.67 percent) holding moderate assets and remaining 43 (17.40 percent) were holding asset of high quality. This shows that elderly females are more dependent on others for their basic necessities as compared to males of similar age group.

3.37: Relationship between Financial Assets and Age of Respondents

The researcher diagnosed the role of increasing age in holding the ownership of financial assets. The present study reveals a significant relationship in between ownership of financial assets and gender as chi-value comes out to be 12.329 which is more than the tabled value i.e. 7.82 at 0.05 level of significance. The findings highlighted the dominance of two age groups i.e. the young-old (65.92 percent) and the old-old (70.72 percent) age group in the possession of financial assets of either high or of moderate quality, whereas, majority of oldest-old age group holds financial assets of very nominal value or had nothing to save. This further makes them dependent on others for their financial needs and hence, making them vulnerable.

Table 3.37: Relationship between Financial Assets and Age of respondents

S. No	Ownership of Financial Assets	Age of Respondents (in yrs.)			Total
		60-70	70-80	80+	
1	Low / Nil	92 (34.07%)	48 (29.26%)	31 (46.96%)	171 (34.20%)
2	Moderate	113 (41.85%)	58 (35.36%)	22 (33.33%)	193 (38.60%)
3	High	65 (24.07%)	58 (35.36%)	13 (19.69%)	136 (27.20%)
	Total	**270**	**164**	**66**	**500**

3.38: Distribution of respondents according to their income sufficiency in fulfilling their basic expenses.

Income sufficiency is related to the level of expenditure and saving. In old age this variable becomes more significant as it reflects the senior citizen's access to basic services including health, food and shelter. An overwhelming majority 206 (41.2 percent) reported that whatever they earn is just equal to their expenditure and they

had nothing to save. This observation is fully supported by the findings of Moneer Alam[61] who undertook his study in the nine districts of Delhi by using primary data obtained from 1000 households and secondary data from NSS 52nd round. He concluded that two-third of the respondents were completely dependent on their respective families as they had no source of earning of their own.

Table 3.38: Distribution according to sufficiency of income.

S. No	Income sufficiency	No of Respondents	Percentage (in percent)
1	Insufficient (Less than expenses)	206	41.2
2	Sufficient (Similar to expenses)	133	26.6
3	More than sufficient (have savings)	161	32.2
	Total	**500**	**100.0**

Similarly, R. Chakroborty[62] in his study found that almost 70 percent of the elder respondents were dependent on others for their financial needs. In this regard, females were highly vulnerable than males. It was also found that only 31percent had independent source of income. Similar findings have been reported by Usha Bambawale[63] based on 864 women respondents of age 60 and above in Pune. Her findings clearly highlighted the vulnerability of female elderly as out of 864 female respondents; 44.44 percent depend on their spouse for their financial needs followed by dependence on son (9.38 percent), daughter (4.86 percent), brother (1.39 percent) and other relatives(16.32 percent). However, the percentage of independent elderly women was reported as 22.92 percent only and they were all getting pensions. The remaining (0.69 percent) respondents did not replied.

I.Rajan[64] also brings forth similar results in his study based on Tamil Nadu, Kerala and Orissa. He reported that most of the respondents had no savings of their own

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61 Alam M. (2006). *Ageing in India: Socio-Economic and Health Dimension.* New Delhi: Academic Foundation. p.315.

62 Chakroborthy, R .(2004), *The Greying of India: Population Ageing in the context of Asia,* Sage Publication, New Delhi, p.304.

63 Bambawale, U. and Streevan. (1996). *Abuse of the Aged.* In Kumar, V. (Ed.). *Ageing:India Perspectives and Global Scenario.* Proceedings of the International Symposium Gerontologyand Seventh Conference of the Association of Gerontology, India. p.301.

64 Rajan, S. I. (2000). *Financial and social security in Old age.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. p.118.

because they spent their whole money in upbringing, education and marriage of their children. In line to this, Saraswati Mishra[65]conducted her study on the retirees of Chandigarh and Jabalpur and found that both- the Chandigarh as well as Jabalpur respondents reported inadequacy of monthly income as amount of Pension was not sufficient to meet their standard of living. This shows that the provision of pension does not ensure quality of life to the senior citizens.

The study further highlighted that 133 respondents (26.6 percent) hold the view that whatever they earn is just sufficient in fulfilling their basic requirements of life. Many replied "the needs have no limits but whatever they earn is enough to bring satisfaction to them". Along with such responses, the study highlighted few respondents who were still having some savings left with them. There were 161 such respondents (32.2 percent) and were mostly educated and belong to higher income group. M. Jain and A. Sharma[66] in their study also observed good economic status hold by majority of respondents; however, very few (4.4 percent) reported that they were economically unable to fulfill their own responsibilities.

In contrast to this, Sharma and Dhakar[67] conducted a study based on 30 respondents and noticed that 6.6percent of the respondents belonging to high economic status were unable to fulfill their family responsibilities. This shows that mere earning is not sufficient. Sometimes the needs even crossed the budget and hence saving requires proper planning and implementation.

M.S. Randhwa[68] compared the savings of rural as well as urban aged and reveals that the urban aged were economically sounder as compared to their rural counter parts due to pension and business etc. Therefore, rural aged were having less savings (67.8 percent) as compared to aged living in urban areas(32.8 percent) and were put under more debt (39.5 percent) as compared to their urban counterparts (7.8 percent). Moreover, Anil Goswami and V.P. Reddaiah[69] try to correlate financial dependence

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65 Mishra, S. (1989). *Problems and social adjustment in old age: A sociological analysis.* New Delhi: Gian Publication House. p.291.

66 Jain, M. and Sharma, A. (2004). *Significance of praductive engagement in work on perceived Death Anxiety.* In Help Age India Research and Development. Vol. 10. No.1. May Issue. p.30.

67 Sharma and Dhakar. (2004). *Lifestyle expectations and problems of rural aged.* In Help Age India Research and Development. Vol. 10. No.3. May Issue. p. 30.

68 Randhwa, M. S. (1991). *The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.42.

69 Goswami, A. and Reddaiah, V.P. (2004). *Self- rated health status of the aged in rural area.* In HelpAge India Research and Development. Vol. 10. No.2. May Issue. p.10.

with health status. They found that only 17.2percent of the respondents were independent while leaving others completely or partially dependent. Out of independent elderly; half of the male and two-third females were having severe health problems, whereas, out of dependent elderly; two-third males and two-third females reported unhealthy status.

3.39: Respondents' awareness of Welfare Measures and Schemes

Over the years, the government has launched various schemes and policies for older persons to promote their health, well-being and independence around the country. In Old age, due to deterioration of physical strength, memory and financial assets; the dependency on welfare schemes increases. But to avail the benefits of these schemes; acquiring awareness and knowledge is must. Keeping this in mind, the researcher introduces the variable 'awareness of welfare schemes' and checked the extent of utilization of welfare schemes by the respondents in Table 3.39. Though many schemes have been introduced by State and Central Government for the welfare of senior citizens; but the present study focuses on the awareness and use of only those schemes which are commonly utilized. First, under these Schemes is the Old Age Pension Scheme (OAPS).

Table 3.39: Respondents' awareness of Welfare Measures

S.No	Welfare Measures	No of respondents			
		Aware	Percentage	Unaware	Percentage
1	Old Age Pension	394	78.8	106	21.2
2	Widow Pension	421	84.2	79	15.8
3	Financial Benefits (Tax reductions/ high interest rates etc.)	182	36.4	318	64.6
4	Travel concession in trains	342	68.4	158	31.6
5	Availability of Old age homes and short stay homes	312	62.4	188	37.6
6	Maintenance and Welfare of Parents and Senior Citizens Act, 2007.	177	35.4	323	64.6

It was found that out of 500 respondents; 394 (78.8 percent) knew the benefit of OAPS, whereas, 106 (21.2 percent) respondents were unaware about this scheme.

'Unawareness' does not signify that the respondents haven't heard of OAPS, rather, it means that they did not know the right procedure of application.

Similarly, on checking the awareness of Widow Pension Scheme (WP), it was found that a large majority of respondents 421 (84.2 percent) were aware of WP, whereas, a very small percentage (15.8 percent) shows unawareness towards it. Furthermore, it was found that only educated respondents 182 (36.2 percent) were aware of Financial Benefits (FB) including Tax reductions and high interest rates on fixed deposits/ savings etc. This is because majority of respondents had no savings.

'Travel Concession' in trains was found to be the welfare scheme mostly utilized by the senior citizens as 342 respondents (68.4 percent) used to take its benefit. This is not due to the awareness of respondents, but due to the smoother implementation of scheme as at the reservation counters, the old age benefits have been given automatically. Likewise, availability of Old Age Homes and Short Stay homes was known to 312 (62.4 percent) respondents, whereas, 188 (37.6 percent) denied to have such knowledge.

Further, with rise in the number of cases of elder abuse and to provide social security in old age, government enacted 'The Maintenance and Welfare of Parents and Senior Citizens Act' in 2007. It was found that a majority of respondents 323 (64.6 percent) were unaware of this initiative and only 177 (35.4 percent) respondents knows this.

Hence, from the above findings it could be inferred that majority of senior citizens were not knowing the schemes meant for their welfare. The primary reason against their unawareness is their lower education. I.Rajan[70]also found the significance of education in the knowledge of various welfare schemes as most of the elderly were found to be unaware of welfare schemes just because of their lower literacy. Similar reason was reported by P. Mohanan and B.S. Sajjan[71] during their study on senior citizens living in old age homes of Mangalore city of Karnataka. They noticed that out of 1026 respondents visited, hardly 10percent were enjoying government old age peosion and 30 percent were enjoying retirement benefits just due to their

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70 Rajan, I. (2006). *Social security for the elderly: Experience from South- Asia*. London: Routledge Press.

71 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi dimensional approach*. In Prakash I.J. (Ed.). Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing And Development. p.118.

unawareness. Further, the male respondents were found to be more aware of the advantages meant for them as compared to females which again show the vulnerability of females.

Similarly, P.N Sati[72] in his study based on needs and problems of aged in Udaipur and Ajmer found that 53.4percent knows about the welfare schemes. On looking into the mode of awareness towards the welfare schemes; it was found that 21.3 percent respondents knew these schemes through relatives and friends, 13.8 percent through media and 18.3 percent through Aganwadi workers. Hence, it could be concluded that although we have a lot of welfare measures for senior citizens, but the unawareness and complexity in the functioning of these measures makes them functionally irrelevant.

3.40 Reasons for not getting Old Age Pension

The Old Age Pension (OAP) is one of the most crucial and commonly utilized schemes of Senior citizens. Hence, the present study highlighted the reasons why the senior citizens were not getting access to Old Age Pension (OAP) (table 3.40).

Table 3.40: Reason for not getting Old Age Pension

S. No	Respondent's view on OAP	No of Respondents	Percentage (in percent)
1	No need	291	58.2
2	Never Try for Old Age Pension	130	26.0
3	Try but not get (due to corruption)	23	4.6
4	Found procedure as difficult	56	11.2
	Total	**500**	**100.0**

The findings show that 291 (58.2 percent) respondents were in no need of any such help as they earn sufficient income to fulfill their daily expenses. Out of remaining, 130 (23.0 percent) never tried for OAP as they thought that they were ineligible, whereas, 56 (11.2 percent) respondents found the procedure as complicated and the amount they received was very less. Those who found the procedure as difficult were generally females, illiterates and belong to the oldest-old age bracket. Out of those

72 Sati, N. P. (1996). *Needs and Problems of Aged. A study for Social Intervention in Ajmer and Jaipur*. New Delhi: Himanshu Publication. p.210.

who had already applied for old age pension; 23(4.6 percent) would not receive it because of corruption they found at every end. They reported that those who have to verify the application either signed the application of close ones only or demand something in return and if not given, took months to sign it. This all shows that although we had appropriate social security measures, but their implementation is very poor. Thus the process of application and distribution should be made easier and transparent.

3.41: Relationship between Awareness of OAP and Education

The table 3.41 gives the relationship between awareness of OAP and education of respondents and it clearly reflects that with rise in education, the level of awareness of welfare measures increases. Old age pension (OAP) is one such measure whose level of awareness also increases with education as the observed value of chi-square comes out to be 12.389 which is more than the expected value (5.991) at 0.05 level of significance.

Table 3.41: Relationship between Awareness of OAP and Education

Awareness of OAP	Education			Total
	Low	Moderate	High	
Unaware	99 (27.80 %)	2 (3.70 %)	5 (5.55 %)	106 (21.2 %)
Aware	257 (72.19 %)	52 (96.29 %)	85 (94.44 %)	394 (78.80 %)
Total	**356**	**54**	**90**	**500**

Out of the total of 500 respondents, it was found that majority of respondents are aware of old age pension scheme. This is because old age pension is the most commonly used welfare scheme available for senior citizens. However, the respondents who are actually utilizing the benefits of such scheme are lesser in number. On looking into the impact of education on awareness; it was found that the respondents who are highly educated are all aware about the OAP as 85 (94.44 percent) respondents reported that they were fully aware of OAP. Similarly, 52 respondents (96.29 percent) from moderately educated group reported their acquaintance with the benefits of Old Age Pension. In addition, majority of

respondents 257 (72.19 percent) belonging to lower education group were also found to be aware of OAP Scheme due to its wider publicity but their level of awareness is not sufficient to help them in utilizing the proper benefit.

3.42: Perception regarding the best way of coping against financial crisis.

Economic hardship is generally the cause of many problems. In old age, it added up with physical dependence and abuse to make the life vulnerable. Since the study aimed at identifying the possible coping mechanisms , the question related to the perception of best coping practices against financial hardship was asked. The basic aim was to check the respondent's rational thinking and attitude towards the handling of economic problems in old age.

Table 3.42: Perception regarding the best way of coping against financial crisis

S.No	Respondents' view	No of Respondents	Percentage
1	Savings/Making investments for old age.	325	65.0
2	Doing job till health permits	73	14.6
3	Keeping immovable assets	41	8.2
4	Socializing children	55	11.0
5	No respond	6	1.2
	Total	**500**	**100.0**

The Table 3.42 clearly indicates that more than half of the respondents; 325 (65percent) were in favour of saving something in initial stages of life. They suggested that everyone must make some investments for old age. However, those who were not in a favour of savings (14.6 percent) commented that whatever one saves would have been all spend in fulfilling their family responsibilities. Hence, to keep something for old age is very difficult and one should work and earn till their health permits. Moreover, forty-one respondents (8.2 percent) were in favour of keeping some immovable assets, whereas, fifty-five respondents (11 percent) gave priority to socialization of children. There were only six respondents (1.2 percent) who did not replied to this question. The findings, therefore suggest that everyone likes to have some savings for old age but the circumstances did not permit them. Further, on the question of socialization of children for providing support in old age; majority hold the view that the youth of present generation are more self-centered and

even socialization does not guaranteed social assistance. Thus saving in the younger years seems to be the best alternative.

3.43: Coping practices adopted by the respondents at the time of financial crisis

Table 3.43 shows the practices adopted by the senior citizens at the time of financial crisis. The findings revealed that a large majority of respondents 137 (27.4 percent) were depending on their children for financial support. They used to ask their children for providing monetary help. However, ninety-six respondents (19.2 percent) reported that they cut down their expenses and manage within the available limits. If the crisis still exists; they became helpless and left everything on god. Out of remaining; five percent reported that they sold out their assets. This was followed by the habit of borrowing money from someone as 77 respondents (15.4 percent) borrowed money from friends, 28 (5.6 percent) borrowed money from relatives, whereas, 43 (8.6 percent) borrowed it from money lenders. However, 5 respondents (1 percent) reported to take loan on their pension and other assets and only one respondent said that he searched for some better employment opportunity. Besides, there were 88 (17.6 percent) respondents who reported that they had no financial crisis in their old age and even earlier because they had good earning and savings as well.

Table 3.43: Coping practices adopted by the respondents during financial crisis

S. No	Coping Practice	No of Respondents	Percentage (in percent)
1	Cut down expenses and left everything on god	96	19.2
2	Sold assets, if any	25	5.0
3	Borrow money from relatives	28	5.6
4	Borrow money from friends	77	15.4
5	Borrow money from money lenders	43	8.6
6	Ask children for help	137	27.4
7	Take loan on pension and financial assets	5	1.0
8	Search for re-employment	1	0.2
9	Have not face any such crisis	88	17.6
	Total	**500**	**100.0**

Similar findings have been reported by M. S. Randhwa[73] in his study based on 360 respondents above 58 years of age from both rural and urban areas. He reported that in rural area, common practices to cope up with financial crisis includes borrow up of money from money lenders, commission agents and cooperate societies and to cut down expenditure according to their needs. In urban areas, elderly used to take help either from their sons or friends, cut down expenditures or withdraw money from their savings.

Hence, from above findings it can be concluded that in old age the expectations to receive help from family and especially from son increases. In fact, many senior citizens are practicing this and in case of any denial, they search for a person from which they can borrow money easily. But what if the borrower denies them to give money by looking into their health and financial status and this is the question which needs serious policy implications.

3.44: Effect of Education on Coping Practices adopted during financial crisis.

There is found a significant relationship between the education and the nature of coping practices adopted by the respondent at the time of financial crisis as shown in table 3.44:

Table 3.44: Education versus Coping Practices adopted during financial crisis.

S. No	Coping with Financial Problem	Education			Total
		Low	Moderate	High	
1	Cut down expenses	79	13	4	96
2	Sold asset (if any)	13	4	8	25
3	Borrow money from Relatives	26	1	1	28
4	Borrow money from Friends	63	8	6	77
5	Borrow from Money lender	42	nil	1	43
6	Ask Children for help	94	14	29	137
7	Take loan on assets /pension	1	nil	4	5
8	Searching for Job or work	1	nil	nil	1
9	Don't face any crisis	37	14	37	88
	Total	**356**	**54**	**90**	**500**

73 Randhwa, M.S. (1991). *The Rural and Urban Aged.* New Delhi: A. H Marwah Publisher. p.39

It was found that those who were highly educated generally hold a good amount of income and financial assets. They were neither facing nor had faced any kind of financial crisis in their present life. If needed, they ask for help from their children. In many cases their children themselves were supporting their parents on a regular basis. However, very few respondents who were highly educated used to cut down their expenses and borrow money from someone.

In contrast, the respondents belonging to lower educated group, generally borrowed money from friends, relatives and money lenders. There were 131 such respondents who were adopting such practice. The reason they gave was simply the neglect and indifferent attitude of their children. The remaining respondents used to cut down their expenses first and then try to ask their children for help. However, only one respondent used to take loan and search for new and high salaried job. In addition, very few respondents belonging to lower educated group were earning good amount and hence they were not facing any kind of financial crisis. Similarly, moderately educated group used to cut down their expenses and ask children for help. Hence, this finding clearly indicates the shift in the pattern of coping from emotion focused to problem focused.

3.45: Respondent's perception of present health status.

Table 3.45 indicates the perception of present health status of the respondents. A large number of respondents (40.4 percent) reported that their health status is 'poor'. Those who reported poor health status were either belonging to oldest-old age group or to the labour class. The reason why the labour class stated their health status as poor lies in their poor financial status and lack of transport facilities. As a result, they failed to receive proper treatment. The 'oldest-old' age group, however, stated that poor health is a natural sign of ageing and everyone has to face some repercussions of health. Similarly, 27.2 percent of the respondents reported their health as 'average', which means that they undergo very small ailments followed by 25.2 percent respondents who perceived their health as 'good' as they had no major health problems instead of B.P., low vision etc. There were only 36 respondents (7.2 percent) holding the perception of having 'very good' health status. They considered their health as 'good' as they do not have any major ailments and were mostly belongs to the young-old age group.

Table 3.45: Respondent's perception of present health

S. No	Perception of Health	No of Respondents	Percentage (in percent)
1	Poor	202	40.4
2	Average	136	27.2
3	Good	126	25.2
4	Very good	36	7.2
	Total	**500**	**100.0**

The findings of Anil Goswami, V.P. Reddaiah et al.[74] fully supported the present findings as they found that majority of senior citizens residing in rural areas perceives their health as 'poor' (66.6 percent) followed by 'quite healthy' (20.6 percent) and 'very healthy' (12.8 percent) perception. In another study, Dr. Saraswati Mishra[75] tries to relate' independence' to that of 'health perception'. The study determines that fully independent elderly (68.42 percent) were having a 'good' perception of their health, whereas, only 4.24 percent partially dependent and 3.68 percent fully dependent respondents were having such feeling. Similar findings have been reported by L.S. Talunker and J. A. Menachery[76] in a micro-level study conducted in Rural Vidarbha where they found 42.9 percent of the respondents enjoying 'good health' whereas, a significantly large number (57.1percent) of respondents opined that their health status was 'bad'.

Gender-wise analysis of health status revealed that majority of males (78.6 percent) considered them as healthy, whereas a very small percentage of females i.e. 19percent had such kind of perception. Further, amongst the females a great majority of widows (84.2 percent) perceived their health as 'bad'. In this regard, Saraswati Misra[77] classified the perception of senior citizens towards their health into five categories as: very bad, bad, ordinary, good, and very good. The findings indicate that the perception of majority of respondents (42.67 percent) towards their health is of

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74 Goswami, A. and Reddaiah, V.P. (2004). *Self- rated health status of the aged in rural area.* In Help Age India, Research and Development. Vol. 10. No.2. May Issue. p. 9.

75 Mishra, S. (1989). *Problems and social adjustment in old age: A sociological analysis.*New Delhi: Gian Publication House. p.31.

76 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha.* In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work InIndia: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280-284.

77 opcit. p.149.

ordinary nature followed by 'good' perception (30.47 percent), 1.53 percent respondents holding 'very good' perception, one-fifth of the respondents (20.87 percent) holding bad perception and remaining 4.47 percent were holding the perception of 'very bad' health status.

Similarly, the findings of T. C. Joshua and D. T. Fiasta[78]reveals that out of 231 respondents; 140 reported that they were suffering from various kinds of ailments and only 99 respondents were keeping 'good' health. However, 42 reported their health status is neither good nor bad. This all shows that younger the individual better will be the perception of their health.

3.46 Respondents' sleeping pattern

'Sleep' is the basic requirement of healthy body and peaceful mind. In old age, the body gets tired very frequently and requires more time for rest. Table 3.46 depicts that majority of respondents 317(63.4 percent) were in a habit of sleeping for more than eight hours a day. This kind of behaviour was more profound in the young-old age group as compared to the old-old and the oldest-old age group. In addition, those who were either living alone are found to sleep more. This behaviour was practiced just because of the plenty of spare time available with them along with their self-consideration of sleep as a mode of protection from getting involved in familial and societal conflicts. It further brought relaxation to them.

Table 3.46: Respondents' Sleeping Pattern

S. No	Sleeping time per day	No of Respondents	Percentage (percent)
1	Below Average (< 5 hrs)	164	32.8
2	Average (b/w 5 to 8 hrs)	19	3.8
3	Above average (above 8 hrs)	317	63.4
	Total	**500**	**100.0**

The above table also highlighted the respondents 19 (3.8 percent) who are in habit of taking a sleep of around five to eight hours a day. This behaviour was generally reported by the 'young-old' and the 'old-old' age group. However, the 'oldest-old' (80 +) age group generally slept for around three to four hours a day. Senior citizens

78 Thomas, C. J. and Diengdoh, F. T. (2010). *Ageing in Meghalaya.* New Delhi: Akansha Publishing House.Vol. 6,p. 142.

who are dependent, earning less, and are living under the pressure of fulfilling many family responsibilities used to show this kind of behaviour. In total, there are 164(32.8 percent) such respondents. Similar findings have been reported by R.K. Punia et.al.[79] in his study based on rural and urban elderly wherein the majority of the rural (75.64 percent) as well as urban aged (55.38percent) did not slept for more than four hours a day because of health problems. This shows that with increase in age, the pattern of sleep also gets affected.

3.47Respondents' Eating Behaviour

Healthy eating habits keep senior citizens energetic and vital. According to American Psychological Association[80], diets rich in folate can help mitigate the feelings of depression, dementia and mental impairment in senior citizens. According to Rural Healthy People Project Report of U.S.A (2010)[81], the risk for chronic diseases in old age can be modified by eating a heart-healthy diet, low in fat and cholesterol. Similarly, the University of Washington[82] reported that a low-fat, low-cholesterol diet can help people cope with arthritis. This shows that healthy eating habits can help a lot in ensuring good health for senior citizens. Disease prevention, increased energy levels and reduced health care costs are another few advantages of healthy diet. Keeping in mind the impact of dietary intake on health problems, the researcher investigated the respondents eating behaviour.

Table 3.47: Respondents' Eating Behaviour

S. No	No. of meals per day	No of Respondents	Percentage (in percent)
1	Four times (3 meals + evening snacks)	86	17.2
2	Three times (breakfast, lunch and dinner)	385	77.0
3	Two times (lunch and dinner)	24	4.8
4	Once a day (lunch)	5	1.0
	Total	**500**	**100.0**

79 Punia, R.K. and Malik et.al. (1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak, T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. pp.56-63.

80 www.livestrong.com

81 Ibid.

82 Ibid.

The question was asked about the number of meals they used to take within a day along with their nutritive value. The above findings revealed that almost two-third of the respondents 385 (77 percent) were in a habit of having meals thrice a day.
However, eighty six respondents (17.2 percent) reported that they used to take some light snacks or fruits in the evening along with three time meals in a day.
The findings also suggested that a very small percentage reported to take meal twice and once in a day i.e.4.8 percent and 5 percent individuals respectively. The findings also revealed that the respondents belonging to lower income group were not having access to any nutritional or balanced diet. Their diet generally contains potato, seasonal vegetables and chapattis. They hardly get fruit, milk, curd, rice, pulses and meat etc., whereas, the respondents belonging to higher income group have access to all seasonal fruits, nutritional diet, white meat, egg, milk and its products , dry fruits and even supplementary health drinks like Chawanprash, Horlicks etc. This shows that income has a direct impact on the nature and access of quality of food taken by the senior citizens.

3.48: Relationship between Dietary Intake and Gender

Healthy Diet is responsible for good health of an individual. Table 3.48 highlighted the gender-wise share of dietary intake of individuals and classified them into three as Below average, Average and Above average diet.

Table 3.48: Relationship between Dietary Intake and Gender

S. No	Dietary Intake	Gender		Total
		Female	Male	
1	Below average	8 (3.23 %)	3(1.18 %)	11(2.2 %)
2	Average	152(61.53 %)	145(57.31 %)	297(59.4 %)
3	Above average	87(35.22 %)	105(41.50 %)	192(38.4 %)
	Total	**247**	**253**	**500**

Below average diet includes the intake of meal once in a day and including chappati with potatoes and seasonal vegetables. They hardly get fruits, milk and other energy giving food. Average diet (three times a day) includes seasonal vegetables, pulses, rice, red meat and fruits (once or twice in a week) whereas, above average diet (three

diet plus evening snacks) includes diet rich in fresh vegetables and fruits, dry fruits, milk and its products, dietary supplements, white meat and pulses etc.

The present findings indicate that gender does not makes any impact on the intake of food habits as the chi-value comes out to be 4.054 which is lesser than the expected value of chi (5.991) at 0.05 level of significance. The present finding indicates that a small proportion of respondents (2.2 percent) were taking below average diet. The pattern was almost similar in both the genders (3.23 percent F and 1.18 percent M). However, a large majority of respondents used to take diet of 'average' nature with a small gender difference (61.53 percent F and 57.31 percent M). Similar is the intake of above average diet in both the genders as (41.50 percent) males and (35.22 percent) females used to take it. The findings further suggest that those who were taking 'average' diet generally belong to middle income group. However, respondents belonging to higher income group were having meals of 'above average' nature. Hence, there exists no significant relationship between the dietary intake and gender.

3.49: Respondent's Ability of doing their Activities of Daily Living (ADL)

Webster's New World Medical Dictionary defines the Activities of Daily Living (ADL) as "the things we normally do in daily living including any daily activity we perform for self-care (such as feeding, bathing, dressing, grooming), work, homemaking, and leisure etc"[83].Health professionals generally use the ability to perform ADL as a measurement of the functional status of a person, particularly in regards to people with disabilities and the elderly. Table 3.49 clearly reveals that in the present study a significant number of respondents 434 (86.8 percent) were doing their ADL by their own, whereas, sixty-six respondents (13.2 percent) reported to seek some help in doing their ADL. This dependency is either due to their illness, major injury or decline of physical strength in the later years of their life (80 and more years).This clearly shows that higher the age of respondent, lower will be his/her ability to perform ADL.

83 www.medterms.com

Table 3.49: Respondent's ability of doing their Activities of Daily Living (ADL)

S. No	Respondents' ability to do ADL	No of Respondents	Percentage (in percent)
1	Able to do by self	434	86.8
2	Unable and needs help	66	13.2
	Total	**500**	**100.0**

In this regard, Moneer Alam[84] in his study based on nine Districts of Delhi reported that a large number of respondents were suffering from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs, etc.) as well as in sensory health domain(hearing and vision) which makes them dependent on formal or informal help in doing their ADL. This dependency was found more acute in lower income group as compared to higher income group. It was also highlighted that females were doing their ADL by their own as compared to males. In another study, A. Bose and M. Kapoor[85] in Delhi observed that majority of respondents who were physically able were also able to do their ADL.

3.50: Intake of unhealthy substances by the respondents

As compared to younger cohorts; intake of unhealthy substances e.g. alcohol, drugs, cigarette, bidi, tobacco etc. is less prevalent in the elderly age group, but still it constitutes a significant health problem. The present findings also revealed that a very large percentage i.e. 302 (60.4 percent) respondents were not in a habit of taking any unhealthy substance. However, a significant population i.e. 198 (39.6 percent) respondents were still taking unhealthy substances on a regular basis. The substance-wise share of intake was given in the following table 3.50.Out of 198 respondents who were addicted to unhealthy substances; 56 respondents (11.2 percent) used to consume Cigarette followed by Bidi, 41 respondents (8.20 percent); Pan with Tobacco, 28 (5.6 percent) respondents; Gutka, 23(4.6 percent) respondents and Alcohol, 15 respondents (3 percent) respectively. Remaining thirty five respondents (7 percent) used to take two or more substances like bidi and alcohol, cigarette and alcohol, bidi and tobacco etc.

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84 Alam, M. (2006). *Ageing in India: Socio-Economic and Health Dimension.* New Delhi: Academic Foundation. p.114.

85 Bose, A. and Kapur, M. (2004). *Growing old in India: voices reveal; statistics speak.* New Delhi: B.R Publishing Corporation. pp. 3-4.

Table 3.50: Intake of unhealthy substances by the respondents

S. No	Substance	No of Respondents	Percentage (in percent)
1	Bidi	41	8.2
2	Cigarette	56	11.2
3	Gutka / Pan Masala	23	4.6
4	Alcohol	15	3.0
5	Pan with tobacco	28	5.6
6	Two or more substances	35	7.0
7	None of these	302	60.4
	Total	**500**	**100.0**

L. S. Talunker and J. A. Menachery[86] in Nagpur District of Vidarbha also found the consumption of tobacco as the most frequent practice amongst the elderly age group (68.5 percent) followed by the consumption of alcohol (14.3 percent); Chillum (51.4 percent) and use of Snuff and Bidi (14.3 percent) etc. Similarly, R.K. Punia et.al[87]reported the habit of smoking in 61.53 percent urban and 52.17 percent rural elderly followed by the intake of alcohol (urban, 4.61 percent and rural, 6.08 percent). Moreover, the consumption of Bhang (17.39 percent) and Opium (2 percent) was also found to be a common practice amongst the rural elderly. This shows that majority of senior citizens are still away from using any unhealthy substance.

3.51: Nature of Health problems faced by the respondents

Although health is the concern of every stage of life, but the level of concern rises as one enters into the old age. This is due to the fact that in old age; physical strength and mental stability deteriorates which in turn leads to many health problems. For the sake of simplicity, the health problems have been classified as minor and major. The minor health problems includes the problems which are not severe in nature like common cold , fever, minor loss of hearing and vision , fluctuations of B.P, pain in

86 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha.* In Raju, S. S., Desai. M. (Eds.). Gerontological Social Work inIndia: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280-284.

87 Punia, R.K. and Malik et.al. (1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak, T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. pp.56-63.

body and headache, whereas, the major health problems include severe ailments like asthma, kidney and lung diseases, diabetes, cancer, T.B., cardiac problem, Osteoporosis, severe memory loss, Alzheimer disease and Dementia etc.

Table 3.51: Nature of Health problems faced by the respondents

S. No	Nature of Health Problems	No of Respondents	Percentage (percent)
1	No Problem	55	11.0
2	Minor Problems	92	18.4
3	Major Problems	353	70.6
	Total	**500**	**100.0**

In this regard, the present finding shows that out of 500 respondents; majority 353 respondents (70.6 percent) were facing the effect of major health problems, whereas 92 (18.4 percent) respondents were undergoing minor health problems. However, a very small number of respondents 55 (11.0 percent) reported that they were not having any kind of health issue and found them as fit. Those who reported no health problems were mostly belonging to the young-old age group whereas, those affected by the major ailments were mostly belonging to the old-old and oldest-old age group. Therefore, the higher percentage of respondents reporting health problems (either major or minor) clearly reveals the fact that in old age, the health of an individual declines. This clearly points out towards the need of providing quality health care to our senior citizens.

3.52 Relationship between Health problems and Gender

In order to check whether the role of gender plays any significant effect on the health of an individual or not the variable 'Health problems' has been introduced. The findings revealed a significant relationship in between the nature of health problems and gender as chi-value comes out to be 9.435 which is greater than the expected value (5.991) at 0.05 level of significance. The table 3.52 clearly indicates that majority of respondents (70.6 percent) were facing major ailments in old age followed by the minor (18.4 percent) and no health problems (11 percent). Further on checking the gender differences, it was found that females were affected more by the major diseases (78.13 percent) as compared to the males (63.24 percent).

Table 3.52: Relationship between Health problems and Gender

Health problems	Gender		Total (in percent)
	Female	Male	
No Problem	21(8.50 %)	34(13.4 %)	55(11 %)
Minor problems	33(13.36 %)	59(23.32 %)	92(18.4 %)
Major problems	193(78.13 %)	160(63.24 %)	353(70.6 %)
Total	**247**	**253**	**500**

In case of minor health problems, males (23.32 percent) outnumber females (13.36 percent). Moreover, more number of males reported no health problems (13.4 percent) as compared to females (8.50 percent). The reason why the majority of females undergo severe health problems is their careless attitude and casual approach towards self along with their dependency on others for treatment. Hence, from above findings it can be easily concluded that with advancement in age; the health imbalances increases. Further, in case of severity of ailments, females are more vulnerable than males.

3.53: Relationship between Health problems and Age of Respondents

It is true that old age brings with it decline in almost every sphere. But this decline generally increases with the age. The present findings also revealed that the severity of health problems increases with age as a significant relationship in between the nature of health problems and age was found with having chi-value comes out to be 23.271 which is very much greater than the expected value of chi square at 0.05 level of significance. The table clearly indicates that majority of respondents in the age group of oldest-old were affected by the major health problems (95.45 percent) followed by minor (18.4%) and no health problems (2 percent). Further, on checking the similar pattern in the other two age groups; it was found to be similar with the oldest-old but with a lower proportion i.e. 83.53 percent in old-old age group and 56.29 percent in young-old age group. This clearly shows that in old-age the health of an individual generally declines; but with the further advancement of age towards death; it reaches to its extreme.

Table 3.53: Relationship between Health problems and Age of Respondents

Health problems	Age of Respondents (in yrs.)			Total (in percent)
	60-70	70-80	80+	
No Problem	48 (17.77%)	7 (4.26 %)	1 (1.51 %)	5 (1%)
Minor problems	70 (25.92 %)	20 (12.19 %)	2 (3.03 %)	92 (18.4 %)
Major problems	152 (56.29 %)	137 (83.53 %)	63 (95.45%)	353 (70.6 %)
Total	**270**	**164**	**66**	**500**

3.54 Distribution of respondents according to Chronic and Other Ailments.

Table 3.54 gives the number of ailments found among the senior citizens. Further, among the health problems; more than half of the respondents (56.8 percent) were undergoing the problem of Arthritis/Joint pain followed by T.B (21 percent) and Cancer (27 percent). Asthma was experienced by a good number of respondents (23.8 percent) belonging to lower income group. In addition, Osteoporosis was reported by 84 (16.8 percent) respondents followed by Kidney problem or Paralysis, 78 (15.6 percent) respondents; Diabetes, 68 respondents (13.6 percent) and Heart and Lung related problems, 45 respondents (9 percent) respectively. Moreover, a small number of respondents; 6 (1.2 percent) were also having the problem of severe memory loss.

Among the minor health problems; the problem of high/low B.P. was reported by 356 (71.2 percent) respondents followed by the problem of Low vision or hearing 312 (62.4 percent) respondents and Cataract 225 respondents (45 percent) respectively. A small group of respondents 25 (5 percent), however reported other health problems which are temporarily in nature like cough, cold, digestive imbalances, minor fractures etc.

Table 3.54: Distribution of respondents according to Chronic and other ailments

S. No.	Health Problem	No. of respondents	Percentage
1.	Alzheimer /severe memory loss	6	1.20
2.	Osteoporosis	84	16.80
3.	Kidney Failure/ Paralysis	78	15.60
4.	T.B. and Cancer	135	27.00
5.	Heart and Lung Problems	45	09.00
6.	Arthritis	284	56.80
7.	Asthma	119	23.80
8.	Diabetes	68	13.60
9.	Cataract	225	45.00
10.	Low Vision and Hearing Problems	312	62.40
11.	High/Low B.P.	356	71.20
12.	Any other (cough, cold, teeth loss, digestive problems, fracture etc.)	25	05.00

(Miscellaneous response)

Almost similar nature of health problems were reported by M.S. Randhwa[88]in elderly residing at rural and urban areas. For instance, in rural areas, the health problems were reported as the teeth loss (27 percent), lower vision (11 percent), heart problem (8percent), kidney trouble (9 percent), asthma (6 percent), diabetes (4 percent), and digestive complaints (5 percent). In urban areas, the health problems were diagnosed as teeth problem (25 percent), pain in joints (25 percent), lower eyesight (16 percent), digestive complaints (10 percent), breathlessness (8 percent), diabetes (6 percent), asthma (7 percent) and pain in chest (3 percent). Findings also show that almost an equal number of respondents from rural (37 percent) and urban (38 percent) areas did not face any kind of ailments. This shows that aged people from all geographical context faces similar kind of health problems. Following similar line, R.K. Punia et.al.[89] also observed no significant difference in the nature of health problems among

88 Randhwa, M.S. (1991). *The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. pp. 42-50.

89 Punia, R.K. and Malik et.al. (1987). *Aging Problems: A study of Rural- Urban Differentials.* In Dak,T.M. and Sharma, M.L. (Eds.). Ageing in India: Challenge for the society. New Delhi: Ajanta Publications. p. 62.

rural and urban elderly as among the general Similar is the findings of L. S. Talunker and J. A. Menachery[90] and T. C. Joshua and D.T. Fiasta[91].

In another study based on 600 elderly people from Manglore, Padma Mohanan et.al.[92] compared the gender differences in health and found that males had more number of chronic illnesses as compared to females e.g. Cataract (30.6 percent M, 19.7 percent F), Diabetes (40.2 percent M, 21.8 percent F), Hypertension (24.6 percentM, 12.8 percent F), Arthritis (5.4 percent M, 6.4 percent F), Asthma (1.9 percent M, 8.8 percent F). In this regard, C.M. Hebibullah[93]also identified some degenerative diseases among the senior citizens including high B.P., coronary and cerebral vascular diseases as the major causes of death followed by diseases found commonly among the older persons including malignant disease, disease of locomotors system, respiratory disease, nutritional and metabolic problems, gastrointestinal disorder, eye diseases, hearing defect, dental problems, accidents, environmental problems, loss of immune function, adverse reactions to drugs and psychological problems. Hence the above findings clearly reflect that in old age, the immune system of the body gets weaken and leads to many health problems.

3.55: Ignorance of Health by the respondents

Ignorance of health problem is very common among the senior citizens. In many cases ignorance may even lead to death. Therefore, the present study diagnoses the behavior of ignorance of health problems by the respondents. The Table 3.55 indicates that a large majority of respondents 402 (80.4 percent) were in a habit of ignoring their health problems; whereas, a small number of respondents 98 (19.6 percent) have shown serious concern towards their health as they never ignored their ailments either minor or major. It was also found that with increase in age, the habit of ignoring health problems also increases.

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90 Talunkdar, L.S. and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha*. In Raju, S. S., Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280-284.

91 Thomas, C. J. and Diengdoh, F. T. (2010). *Ageing in Meghalaya*. New Delhi: Akansha Publishing House.Vol. 6.p. 142.

92 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi dimensional approach*. In Prakash,I.J. (ed.). Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing And Development. p.118.

93 Hebibullah, C.M. (1996). *Health Care in the elderly*. In Kumar,V. (Ed.). Ageing: India Perspectives and Global Scenario: Proceedings of the International Symposium on Gerontology and Seventh Conference of the Association of Gerontology. India. p.99.

Table 3.55: Ignorance of Health by the respondents

S. No	Ignorance of Health Problems	No of Respondents	Percentage (in percent)
1	Ignore	402	80.4
2	Don't ignore	98	19.6
	Total	**500**	**100.0**

Further, a significant difference in the level of ignorance towards minor and major health problems was observed. The elderly ignored the treatment of minor health problems more frequently as compared to major ones. As a result, many times their minor problems turn out into a major one. This sense of ignorance was reported generally because of financial crunch and their consideration of health problems as the normal sign of ageing. In many cases, the respondents ignored their health problems because they do not want to make themselves a burden on their family.

3.56: Relationship between Ignorance of health problems and Age of respondents.

The earlier finding clearly indicates that in old age the ignorance of health problems increases. However, there is found no significant relationship in between the increasing age of respondents (young-old, old-old and oldest-old) and ignorance of health problems as chi value comes to be 3.255 which is lower than the expected value (5.991) at 0.05 level of significance. The table 3.56 reflects that out of 500 respondents; majority; 402 (80.40 percent) were in a habit of ignoring their health problems, whereas, a small number of respondents 98 (19.6 percent) seems conscious about their health.

On looking into the age-wise composition of respondents, there is found no significant difference in between the age of respondents and ignorance of health problems as 80.37 percent respondents from 60 to 70 age group, 77.43 percent respondents from 70 to 80 age group and 87.87 percent respondents in the age group of 80 years and above were all in a habit of ignoring their health problems. However, only 19.6 percent never ignored their health problems including 19.62 percent respondents from 60 to 70 age group, 22.56 percent from 70 to 80 age group and 12.12 percent respondents belonging to the age group of 80 years and above.

Table 3.56: Ignorance of health problems vs. Age of respondents

S. No	Ignorance of Health	Age of respondent			Total
		60-70	70-80	above 80	
1	Ignore	217(80.37 %)	127 (77.43 %)	58 (87.87 %)	402 (80.4 %)
2	Not Ignore	53 (19.62 %)	37 (22.56 %)	8 (12.12%)	98 (19.6 %)
	Total	**270**	**164**	**66**	**500**

Hence, almost equal percentage of respondents in all the age group ignores their health problems and thus it could be concluded that there is no impact of age on the ignorance of health problems.

3.57: Ignorance of Health problems of the respondents by their family members.

These days, a phenomenon called 'grand dumping' is becoming very common in urban areas. 'Grand dumping' signifies the ignorance of parent's or grandparent's health by their children. It also includes the consideration of old parent's or grandparent's as a burden and dumping them into the old-age homes or even out of their houses without providing any meaningful accommodation.

Table 3.57: Ignorance of Health problems of the respondents by their family

S. No	Ignorance of Health Prnblems	No of Respondents	Percentage (in percent)
1	Ignore	135	27.00
2	Don't ignore	365	73.00
	Total	**500**	**100.00**

The above table indicates that out of the total of 500 respondents, a significant percentage (27 percent) were facing the problem of ignorance of health by their children, whereas, a large majority of respondents 365 (73 percent) reported that their family had never shown such act of ignorance in case of any health problem (either minor or major). The basic reason they reported for their care and concern was the prevalence of joint family system. Those who reported ignorance by the family

members generally belongs to 'old-old' and 'oldest-old' age group. They lost control over their bodies and undergoes many health problems. As a consequence, their children considered them as a burden and started ignoring them. The other reasons for the ignorance by the family members have been discussed in next table.

3.58: Reason for ignorance of health by the family members

Neglect of senior citizens is becoming a common practice these days. Elder generation is neglected because of their poor health, shabby looks and inability to show smartness like the younger generation. Table 3.58 is suggesting the reasons for the ignorance of health of senior citizens by their family members.

Table 3.58: Reason for ignorance of health by the family members

S. No	Reason for Ignorance of health by the family members	No of Respondents	Percentage (in percent)
1	Selfish attitude	50	10.00
2	Busy schedule	62	12.40
3	Consider as normal sign of ageing	23	04.60
4	Never ignore	365	73.00
	Total	**500**	**100.00**

The findings although revealed that in Aligarh, majority of respondents 365 (73.0 percent), were never ignored by their family members either because of the traditional practices of giving weight age to senior citizens or due to religious consideration of treating elderly as the head of household till death. But still the ignorance was noticed in case of 27 percent of the respondents. They reported that their family never paid attention to them at the time of their illness and other needs just because of their the selfish attitude (10 percent); busy schedule (12.4 percent) and the consideration of falling health as a normal sign of ageing by the children and other relatives (4.6 percent). The busy schedule of children is responsible for neglect as both men and women were engaged in multitasking roles and it hampers their primary role of a caregiver. Selfish attitude was a problem due to their limited resources and lack of socialization i.e. they used to give priority to their personal needs and to the needs of

their children. Today's youth want to spend a lavishing lifestyle and for that they ignored the expenses from where they found no return. Spending money on parent's treatment and care is one such expense. Thus, from above findings it can be concluded that the life of senior citizens in Aligarh is still better than the life of elderly residing in metropolitan cities.

3.59: Person doing care giving role for the respondents

The concept of care giving and developing a cadre of care givers is the emergent need of present generation and especially in urban areas, where the culture of nuclear family is more profound. Care may be provided by formal or informal caregivers. Informal care can be offered by family members, friends or relatives, often in a home setting whereas, formal care was provided by the community or the institutions. Caregivers not only provide assistance to senior citizens at the time of disability, chronic illness or cognitive impairment but also help them in performing their Activities of Daily Living. In the present study, the informal care giving has been considered. Informal care givers were also called the primary care givers.

Table 3.59: Person doing care giving role for the respondent

S. No	Caregiver's Relationship with the respondent	No of Respondents		Total (Percentage)
		M	F	
1	Spouse	104	162	266 (53.2 %)
2	Son	91	_	91 (18.2 %)
3	Daughter	-	41	41 (8.2 %)
4	Daughter- in-law	-	62	62 (12.4 %)
5	Relatives	9	_	9 (1.8 %)
6	Neighbours and friends	12	_	12 (2.4 %)
7	Servant	5	3	8 (1.0 %)
8	No-one	11	_	11 (2.2 %)
	Total	**232**	**268**	**500 (100.0 %)**

In the present study, it was found that in most of the cases, a single individual carries the burden of care giving. The table indicates that about half of the respondents 266 (53.2 percent) were taken care by their spouse followed by siblings including son

(18.2 percent) and daughter (8.2 percent) as their primary caregivers. Similarly, the other caregivers include daughter-in-law, 62 respondents (12.4 percent); neighbours and friends, 12 respondents (2.4 percent): relatives, 9 respondents (1.8 percent) and servants 5 respondents (1.0 percent) respectively. However, very few respondents 11 (2.2 percent) reported no caregiver at the time of their illness.

The findings of P. Mohanan et. al.[94]fully supported the present findings as she reported the caregivers as self-care; 140 respondents(22 M, 118 F); spouse ;148 respondents (120M, 28F); son and daughter-in-law; 130 respondents (20 M, 110 F); grand-children; 72 respondents (12 M, 60 F) and others; 57 respondents (18 M, 39 F). Similarly, Anne Gray[95] in Great Britain suggested that with increase in age, care giving was restricted to spouse or adult children only rather than to non-kin and relatives. Those who are living alone are cared by their friends.

The study further reflected women as the primary caregiver as compared to their male counterparts as 57.2 percent women were doing care giving role. The findings are totally in agreement with the findings of N. Banu and C. Mayuri[96] where also majority of caregivers were females (73 percent) and especially housewives. Besides, most of the caregivers (83 percent) were living with their spouse. Hence, from above findings it can be concluded that 'spouse' is serving as the primary caregiver in old age. It further shows the relevance of marriage and life partner in the old age.

3.60; Respondents Preferred System of Medicine

The Indian Systems of Medicine falls in the oldest and organized 'Systems of medicine' available in the World. The Indian system of medicine generally consists of Ayurveda, Siddha, Unani, Homoeopath, Allopath, Yoga and Naturopath. Each system, however, is unique and efficient in its own way but still the availability and people's faith makes a lot of difference in their utilization. This question was asked just to check the availability and people's inclination towards a particular system of medicine so that those services can be improved and made easily available for the senior citizens.

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94 Mohanan, P. and Sajjan, B.S. (2005). *Problems of the aged: a multi dimensional approach.* In Prakash, I.J. (Ed.., Ageing in India: retrospect and prospects. CCR-IFCU. Project Report on Ageing and Development. p.118.

95 Gray, A. (2009) . *The social capital of older people in Great Britain.* In journal Ageing and Society: Cambridge University Press. Vol. 29. No. 1. Jan 2009. pp.29, 62.

96 Banu, N. and Mayuri, C. (2005). *Determinants of the caregiver's in the context of Care giving.* In Indian Journal Of Social work. Vol. 66. No. 2-4. pp. 175-195.

Table 3.60: Respondents Preferred system of medicine

S.No	Preferred system of medicine	No of Respondents	Percentage (percent)
1	Ayurveda	50	10.00
2	Homeopath	62	12.40
3	Unani	23	4.60
4	Allopath	365	73.00
5	Other (Yoga/Naturopathy/ Acupuncture etc.)	Nil	Nil
	Total	**500**	**100.00**

In this regard, it was found that out of the total of 500 respondents; majority (73 percent) were in a habit of utilizing 'Allopath' followed by 'Homeopath'62 respondents (12.4 percent), 'Ayurveda' 50 (10 percent) respondents and 'Unani' 23 (4.6 percent) respondents respectively. It was also found that none of the respondent follows Yoga, Naturopathy and Acupuncture as their preferred choice.

Therefore, 'Allopath' is the most frequent choice of medicine among the senior citizens because of it's easy access, cost effectiveness and quick results. Dr. Saraswati Mishra[97]also identified Allopathy, Homeopathy and Ayurveda as the three major systems of medicines frequently utilized by the senior citizens. Out of these; 61.67 percent preferred Allopath, 28.93 percent respondents did not use any type of treatment while rest of the respondents (7.07 percent) preferred Ayurveda and Homeopath (2.33 percent) respectively.

3.61Source of treatment adopted by the respondents

'Source of treatment' describes the nature of services utilized by the respondents including government hospitals, private hospitals, local practitioners and chemist etc. The place from where the senior citizens got treated is important as it clarifies the lacunae presented in the present system of medicine, especially the government services. Important here is to know that whether our senior citizens utilized

97 Mishra, S.(1989). *Problems and social adjustment in old age: A sociological analysis*. New Delhi: Gian Publication House.p.12.

government services or not and if not, why? The following Table 3.61 describes the source of treatment adopted by the respondents:

Table 3.61: Source of treatment adopted by the respondents

S. No	Source of treatment	No of Respondents	Percentage (in percent)
1	Pvt. Hospitals	6	1.2
2	Pvt. Doctors	279	55.8
3	Government hospitals/CHC	104	20.8
4	Vaid / Hakim	27	5.4
5	Quacks	42	8.4
6.	Chemist shop	38	7.6
7	Satsang / Free health camps	4	0.8
	Total	**500**	**100.0**

The present findings reveal that more than half of the respondents 279 (55.8 percent) used to take the help of doctors during their major ailments; however, government hospitals were approached by only 104 (20.8 percent) respondents. In addition, Quacks 42 (8.4 percent), Chemist shop 38 (7.6 percent), Vaid / Hakim 27 (5.4 percent), Pvt. Hospitals (1.2 percent) and Satsang / Free health camps (0.8 percent) were utilized. Findings also suggests that those who were utilizing private health services belongs to higher and middle income groups whereas lower income group generally follows government health services. This shows that government health services are still serving as a lifeline to poor people.

3.62: Reason for utilizing the preferred Medicinal System

In order to check the reason behind the utilization of specific medicinal system the question as to what extent they are utilizing such system and why has been asked. In response, the majority of respondents 249 (49.6 percent) reported that they were utilizing the particular system because of good services and effective results. However, another 194 (38.8 percent) respondents reported the reason behind their utilization of such services was the availability at lower cost. The remaining respondents (10 percent) preferred respective system of medicine just because of its easy accessibility as they don't want to travel a long distance and especially during

the time of illness. A very small group of respondents (1.6 percent), however, reported that they utilize such service because they had no other choice. Hence, they were forced to opt for the same.

Table 3.62: Reason for utilizing the preferred Medicinal System

S. No	Reason for utilization	No of Respondents	Percentage (in percent)
1	No other alternative is left	8	1.6
2	Cheaper	194	38.8
3	Nearer	50	10.0
4	Provide good services	248	49.6
	Total	**500**	**100.0**

The above finding shows that almost half of the respondents utilize the health care facilities under certain constraints. Constraints may be the financial crunch; difficult access and the transport problem etc. Hence, some alternatives should be drawn for the proper health care services as required by the senior citizens.

3.63: Problem in utilizing government health care services

The government provides health care services at three levels; namely, primary, secondary and tertiary level. The primary level includes rural health centers and urban health centers; secondary level includes ESI/PSU hospitals, Community Health Centres and District hospitals, whereas tertiary level includes medical colleges and Research Institutes[98]. Even though we had a well- organized health care system at all levels, but it has not been utilized by many. The table 3.63 identified the reasons for non-utilization of health care services as given by the government. The findings reveal that more than half of the respondents 289 (57.8 percent) were not utilizing the government services because of overcrowding followed by negligence of staff (14.4 percent), transport problems (10.0 percent) and financial crunch (9.0 percent) etc. In addition only 8.8 percent respondents did not face any problem in utilizing the government services. This is because they were having their links in the hospitals.

98 www.indianhealthcare.in

Table 3.63: Problem in utilizing government health care services

S. No	Problem in government hospitals/ PHCs/CHCs	No of Respondents	Percentage (in percent)
1	Financial problem	45	9.0
2	Transport problem	50	10.0
3	Overcrowding	289	57.8
4	Negligence by staff	72	14.4
5	No problem	44	8.8
	Total	**500**	**100.0**

Similarly, in the study of M.S. Randhwa[99] it was observed that 52.8percent rural and 47.2 percent urban respondents did not received the proper care in the hospitals. Similar is the findings of Dr. Saraswati Mishra[100] where government hospitals were preferred by only 29.25 percent respondents followed by nursing homes ;6.85 percent respondents and private doctors ; almost half of the respondents (50 percent) respectively. Higher proportion preferring private services mostly due to the negligence they observed in the government Hospitals. In addition, L. S. Talunker and J. A. Menachery[101], in their study on rural Vidharbha in Nagpur district observed that 77.1 percent of the senior citizens contacted city based private doctors or Hospitals for regular medical treatment. Although the village had PHC; none of the respondents preferred this facility due to dissatisfaction from services.

In similar line, A. K. Panda[102] try to assess the quality of treatment received by the senior citizens in the government hospitals and found inappropriateness in service (27 percent) and not up to mark 'care' given in the hospitals(17 percent). In addition, 1.4percent maintains mobile care units, and 38.6percent reported that medical camps were organized in their areas for once in a year. In addition, C. J. Thomas and F. T.

99 Randhwa, M.S. (1991). *The Rural and Urban Aged.* New Delhi: A.H Marwah Publisher. p.49.

100 Mishra, S. (1989). *Problems and social adjustment in old age: A sociological analysis.* New Delhi: Gian Publication House. p.12.

101 Talunkdar, L.S and Menachery, J.A. (2000). *Social Work Intervention with the Ageing in rural areas: A Micro-level study in rural Vidarbha.* In Raju, S. S. and Desai, M. (Eds.). Gerontological Social Work in India: Some issues and perspectives. New Delhi: B.R. Publishing Corporation. pp.280.

102 Panda, A.K. (2008). *Elderly Women in Madhya Pradesh: Condition and Challenges.* In HelpAge India, RandD Journal, Vol. 14, No.2 May Issue. p.162.

Diengdoh[103] in their project on 'Ageing in Meghalaya' almost came up with similar results as he noticed that those who were utilizing government hospitals expressed dissatisfaction over services (40 percent), complaints of waiting for a long time (16 percent) followed by the problem of getting no attention by the doctors (10 percent), not provide proper medicine (9 percent) and finally, not receive well attention and care by other staff (8 percent). This all shows that the government health care facilities need to be made 'elder friendly'. The overcrowding which was found to be the basic cause behind the non-utilization of government services should be dealt carefully.

3.64: Use of helping aid as a means of coping versus age of respondents.

Today the world is becoming technology driven. There is an increase in the nature and number of machines utilized by everyone; senior citizens are no more exception. For senior citizens, many helping aids were designed by the government and private bodies including digital monitor for diabetes, special walkers, spectacle, hearing aid, B.P monitor, oddly shaped reading material, portable magnifier, wheel chair and notebook etc. The basic motive of these helping aids is to make the life of senior citizens simpler and comfortable.

Table 3.64: Use of helping aid versus age of respondents.

S. No	Use of helping aids	Age of respondent			Total
		60-70	70-80	above 80	
1	Non users	124 (45.92 %)	44 (26.82 %)	8 (12.12 %)	176 (35.2 %)
2	Users	146 (54.07 %)	120 (73.17 %)	58 (87.87 %)	324 (64.8 %)
	Total	**270 (100 %)**	**164 (100 %)**	**66 (100 %)**	**500 (100 %)**

The table 3.64 clearly suggest that out of 500 respondents; only 176 (35.2 percent) respondents were not using any kind of helping aid, whereas, majority of respondents 324 (64.8 percent) were utilizing one or the other helping aid to make their life

103 Thomas, C. J. and Diengdoh, F. T. (2010). *Ageing in Meghalaya.* New Delhi: Akansha Publishing House. Vol. 6.p. 77.

simpler. The table further indicates that the age of respondents has a significant relationship with the use of helping aid (chi value = 14.068 > 5.991 at 0.05 level of significance) as amongst the users; 146 (54.07 percent) belong to young-old age group, 120 (73.17 percent) to old-old and remaining 58 (87.87 percent) respondents falls in the age group of 80 years and above. However, 124 (45.92 percent) respondents from 60 to 70 age group, 44 (26.82 percent) from 70 to 80 age group and 8 (12.12 percent) in the above 80 age group are not using any kind of helping aid. This shows that in old age, a person generally depends on helping aids and this dependency increases with age i.e. from 'young-old' to 'old-old' and to the 'oldest-old' age group. Hence, cheaper technology and sensitization towards the use of technology is needed for the proper utilization of equipment meant for the welfare of senior citizens.

3.65: Use of Health insurance as a means of coping versus the age of respondents

Insurance is considered as a form of long-term saving for senior citizens. The insured money not only provides financial stability, but also helps senior citizens in times of financial needs. Medical and health insurance is one such form of insurance which generally covers health checkups, emergency medical costs and long-term treatment expenses. Now a day's Health insurance is provided by both private as well as public sector undertakings. There exist a large number of insurance schemes especially designed for the welfare of senior citizens and which are giving exorbitant returns to them. The table indicates that the age of respondents has a significant relationship with the use of health insurance (chi value = 12.931 > 5.991 at 0.05 level of significance) Table 3.65 further indicates that majority of respondents 381 (76.2 percent) were not having any kind of health insurance. It was also found that 119 (23.8 percent) respondents who were having health insurance are either belonging to higher income group or to the public sector. The respondents' belonging to public sector were insured not because of choice but due to chance as the insurance was given by the government. Further, the majority of them were found to be unaware of the exact benefits of health insurance.

Table 3.65: Relationship between the Use of Health Insurance and Age of respondent

S. No	Use of Health Insurance	Age of respondents (in yrs.)			Total
		60-70	70-80	above 80	
1	No	205 (73.21 %)	115 (78.23 %)	61 (83.56 %)	381 (76.2 %)
2	Yes	75 (26.78 %)	32 (21.76 %)	12 (16.43 %)	119 (23.8 %)
	Total	**280 (100 %)**	**147 (100 %)**	**73 (100 %)**	**500 (100 %)**

On looking into the age-wise use of health insurance; it was found that 205 (73.21 percent)respondents from 60 to70 age group, 115 (78.23 percent) from 70 to 80 age group and remaining 61(83.56 percent) respondents in the age group of 80 years and above are not utilizing the benefits of any kind of health insurance. However, 75 (26.78 percent) respondents from 60 to 70 age group, 32 (21.76 percent) from 70 to 80 age group and 12(16.43 percent) in the age group of 80 and above were utilizing the benefits of health insurance. The table therefore shows that with increase in age, the respondents preference of utilizing the benefits of health insurance decreases. This shows that in old age, people generally refused to have medical insurance. The reasons cited were their belief that the procedure to get return is complicated, unawareness of the benefits and schemes of health insurance and finally considering insurance as against the laws of Islam. Out of these, ignorance was found to be the basic cause behind the non-utilization of health insurance as a means of coping against the health problems.

3.66: View on having Health insurance as a means of coping

On looking into the respondents own choice of deciding health insurance as a means of coping against the health problems; it was found that a small but significant number of respondents 102 (20.4 percent) denied for having health insurance as they considered insurance as a wastage of money and time. They opined that instead of investing into health insurance, they must invest in some other savings which can be used up easily at the time of their need.

Table 3.66: View on having Health insurance as a means of coping

S. No	Respondents View	No of Respondents	Percentage (in percent)
1	One must have health insurance	389	77.8
2	No need	102	20.4
3	No response	09	1.8
	Total	**500**	**100.0**

However, a large majority of respondents 389 (77.8 percent) considered health insurance as a healthier practice. The remaining 9 (1.8 percent) respondents did not reply as they were totally unaware of the concept of insurance. The present study therefore suggests that in old age people understand the relevance of having health insurance but due to financial crisis and some other reasons; they themselves were not utilizing its benefits.

3.67: Healthy life styles followed by the respondents

As one advances towards old age, one has to necessarily face some ailments. But these ailments and their effects can be reduced, if not stopped, depending upon the life style and environment followed by them. Therefore, preventive measures in terms of healthy life styles like regular exercises, regular walking, doing exercise or yoga, taking nutritious diet, keeping them busy, managing stress, going for regular health checkups etc. are needed for reducing the ill effects of ageing. Out of the total of 500 respondents; a majority 207 respondents (41.40 percent) were in a habit of following one or two healthy life styles, whereas, 201(40.20 percent) respondents followed in between three to five healthy life styles in their daily routine.

Table 3.67: Number of healthy life styles followed by the respondents

S. No	Healthy life styles	No of Respondents	Percentage (in percent)
1	Nil	22	4.4
2	Follow one or two	207	41.4
3	Follow three to five	201	40.2
4	Follow six to eight	70	14.0
	Total	**500**	**100.0**

In addition, there were 70 respondents (14 percent) who used to follow between six to eight life-styles on a regular basis. However, a very small number of respondents 22(4.4 percent) denied to follow any such activity in their life. Further, it was found that the respondents who were either bed ridden or belong to 'oldest-old' age group (80 + yrs.) were not following any such healthy life styles. Instead, those who belong to the 'young-old' and the higher income group were showing more concern towards their health. They were in a habit of following in between seven to eight healthy practices on a regular basis. This shows that with increase in age; the individual's life styles get changed. The higher the age, the lesser will be the desire to remain active and hence, the lesser will be their involvement in follow up of healthy life styles.

3.68: Nature of healthy life-styles followed by the respondents

The Table 3.68 attempts to explore the nature of healthy life styles followed by the senior citizens in actual. No doubt, healthy lifestyles makes one feel energetic, fit and at reduced risk for disease. The table depicts the pattern of lifestyles followed by the elderly in Aligarh and suggests that a good number of respondents 226 (45.2 percent) used to go for a walk in the morning, 45 (9.0 percent) respondents do yoga or exercise, 125 (25.0 percent) visit their near ones frequently, whereas, 32 (6.4 percent) respondents organized tour.

Table 3.68: Follow-ups of healthy life-style by the respondents

S.No	Follow-up of healthy life-styles	No of Respondents	Percentage (in percent)
1	Going for a walk	226	45.2
2	Doing yoga or exercise	45	9.0
3	Visiting near ones	125	25.0
4	Organizing tours	32	6.4
5	Regular checkups of health	27	5.4
6	Balanced diet	80	16.0
7	Participation in social/political activities	186	37.2
8	Gaining knowledge on old age issues	49	9.8
9	Any other (keeping pets, cycling etc)	55	11.0

(Miscellaneous responses)

Further, very few respondents were in a habit of having routine health checkups; 27 respondents (5.4 percent) followed by the habit of having balanced diet; 80 (16.0 percent) respondents and gaining knowledge on old age issues; 49 respondents (9.8 percent) respectively. The findings also revealed that more than one-fourth of the respondents (37.2 percent) spend their time in participation of social and political events. Keeping pets, cycling and swimming etc. was reported by 55 (11 percent) respondents. Therefore, from above findings it can be concluded that majority of senior citizens are not following healthy life styles in their daily routine.

3.69: Evaluation of old age by the respondent

Old age leads to different experiences for different people. Some enjoy their old age as a period of freedom from responsibilities, whereas, other considers it as a most painful experience as it makes them dependent even for their basic needs. The Table 3.69 indicates that out of 500 respondents, 210 (42.0 percent) were taking their old age as a 'normal experience', whereas 206 respondents (41.2 percent) considered it as a 'curse'. Those who evaluated their old age as a curse, belong to 'oldest-old' age category and were generally belonging to middle and lower income group and were suffering from severe health problems. This whole combined to give them a feeling of old age as a burden or a curse. The findings further revealed that only 55 (11.0 percent) respondents evaluated their old age as a 'period of freedom from responsibilities', whereas, 29 (5.8 percent) respondents consider their old age as an 'achievement'. Those who reported old age as an achievement were generally belonging to higher income group, possess higher education and were free from all physical ailments.

Table 3.69: Evaluation of old age by the respondent

S .No	Evaluation of old age	Frequency	Percent
1	Curse	206	41.2
2	Normal Experience	210	42.0
3	Period of freedom	55	11.0
4	Achievement	29	05.8
	Total	**500**	**100.0**

This shows that old age becomes a curse to those who are living in poor financial and health situations, whereas those sharing all the basic amenities of life and the good familial and societal positions were all enjoying their old age like. They considered their old age as a normal experience of life. For them, nothing has changed. Those having positive attitude towards life and having good name and fame considered their old age as an achievement.

CASE STUDIES

In order to support the findings of the present study and to understand the situation of aged in totality; the following case studies have been conducted:

Case Study-01

Mr. Khurshid, 92 years, belonged to a family of very poor financial status. He had four sons and two daughters. His spouse is fifty-five years old .The daughter was eldest amongst all. All of them were living in a single room. The house was rented and they were living there since they have shifted to Aligarh. In Aligarh, he was running a dhaba near his house. His unmarried sons used to support him in running his dhaba. Everything was going well and smoother for him till two years back but unfortunately on one morning; he fell down from his roof while repairing it. As a result, his leg got fractured and he got some injuries on his head. He did not take that seriously and uses some home remedies. When the problem further increases; he used to take pain killers without the recommendation of any doctor. Due to this gross negligence of injury; his problem further increases and ultimately made him bed-ridden. Then he went for treatment at government hospital where he got hospitalized for few months. Till the time of data collection; he was put on medication and under hed rest. As a result of his long lasting illness his family got totally disturbed as they were facing many difficulties out of his illness e.g. the money which they saved for the marriage of their daughter and for the purchase of their own house was all spend on the treatment and medication of Khurshid. However, everyone in the family was depressed but Khurshid was the only person who shows positive attitude towards life. Although, he knows that he has no means to cope up with financial crisis which his family was facing but still he was thankful to the almighty for giving him a chance to solve his problems. He believes that problems are the part of life and by concentrated efforts they will all gone. He himself was showing his full interest in going back to work as soon as his health permits him to

do so. This shows his optimistic nature. His wife also narrates an interesting story about him by stating that Khurshid was born in Kashmir. In his adolescence stage, he ran out of his house in want of becoming a big person with having lots of fame all around. Thus he visited many cities and finally decided to get settled in Aligarh. Since then he never turned back to his hometown. Though at the time of his illness, he was seriously missing his close kin, but he didn't tell this to anyone, except his wife. This shows that he is an introvert as well. He had a lot of things to share and many feelings to explore.

Case Study-02

"Sadaqat Hussain", 72 years, was a resident of Sir Syed Nagar. Forty years back he came to Aligarh in search of a high salaried job. In 1972, he got a managerial job in nationalized bank and since then he was living in Aligarh. Recently, he is retired from his service and is living in the same locality as he earlier used to live. He has two children, one son and one daughter. Son is settled in U.S.A whereas; the daughter is married in a reputed family of Aligarh. She used to visit her on every weekend, whereas; the son visited him after every year or two. He lost his wife last year and is finally living with a servant who used to take care of him. Even though he used to live alone but he always try to keep him engaged in activities like visiting near ones; watching T.V; Gardening; taking a walk; doing religious practices etc.

Despite his all engagements; many times he used to felt lonely. This is because of the sad demise of her wife. He was very much attached with his wife and used to miss her in every walk of his life. Even while describing his family members; tears fall into his eyes. Regarding his wife, he reported that his wife was very caring and loving. He shared everything with her. But presently, he has no one to share his sorrows and joys. Sometimes, he even visited her daughter's residence to share his sorrows and negative feelings; but he failed. The reason he cited was the unsuitability of time and the engagements of her daughter in her household jobs. Further, he didn't want to make her life disturbed. In addition to her wife' he was also having two more friends with whom he used to share everything but unfortunately, one has shifted to Bangalore at his son's residence, whereas, the other one was died due to heart attack just nine months before. Presently, he is all alone with his memories and sorrows. This shows that in old age; marital status plays a significant role in curbing the feeling of loneliness and especially in higher income groups; where the social networks are limited to household only. The

presence of spouse in old age makes the life easier, relaxed and with less stressors. It also guarantees social security.

Case Study-03

Yasmeen, a widow aged 85 years; is living with her son and daughter-in-law. Yasmeen was settled in Aligarh for past 60 years. She is illiterate and came to Aligarh with her husband after her marriage. Both of them were daily wagers at the time of their earning and hence they would not save anything for their old age. Moreover, she was not having any financial assets. Presently, she had three daughters and one son. Since all her daughters are married; so she used to live with her son's family. She is also facing some severe health problems and was very weak to earn. Whatever she has is the possession of few hens and ducks. She used to sell their eggs for getting some money out of them. But unfortunately, the amount she was getting was not sufficient even to bring her a full day's meal. Hence, she becomes fully dependent on her son. Her dependency makes her vulnerable to undergo verbal and even physical abuse sometimes. The abusers were her son and daughter-in-law. They didn't even serve three times meal to her. Sometimes, they used to give chapattis without vegetable and if vegetable was served; it was not fresh. Fresh food they used to keep for themselves and if the lady dares to complaint; they all started shouting on her and kept her silent. On looking into this behavior, her neighbours sometimes took her to their houses and offered some food to her.

Her miseries never end here; at the time of her illness she was never provided with proper medication and care. Nobody from her family turned up to look her. Instead, they scolded her for making them disturbed during their sleep. At one hand, her age didn't allow her to stay healthy and getting dependent is her liability, whereas on the other hand, her family was not ready to accept her. Every day she felt disturbed, both mentally and emotionally. This all makes her feel like dying. She considered her life as a 'burden' and always prays for her death. Despite of all these inhuman behaviours, she still wants to live with her son and his family as she replied with "No" while responding to the question that "whether you want to live in old age home, if offered free of cost?" This shows her sheer love towards her family and place of living as she spends her whole life there with sharing so many memorable moments. In addition, she thought that shifting to any old age home would bring defame and a cross on the character of his son. Further, it affects the life of her married daughters. This suggests that people in

their older years didn't want to accept changes easily, This is either due to social obligations or due to ignorance. They had their own conception of life, emotions and feelings etc. and they didn't want to come out of it. Further they don't want to make adjustment with the younger generation.

Case Study-04

Ismael Khan, 82 years; was a resident of Hamdard Nagar. He was a widower, living in a joint family of two married sons, daughter-in-laws and their grandchildren. Besides, he has two daughters, married in the same city; that he used to visit regularly and especially in the time of trouble. He was suffering from many health problems like Arthritis, T.B and Kidney failure. Treatment of these ailments requires a lot of money, which he himself couldn't afford as he has no source of his personal income. The dilemma further increases when the money was not even provided by his sons. Thus he was forced to ignore the treatment of his health problems. Although he was thinking of applying for the Old Age Pension many times, but due to his dependency on his children for filling up of application form and other proceedings, he could not do that.

Ismail's miseries never end here. Being the owner of his house, he was always put under pressure to engrave the house on the name of their sons and daughter-in-laws. Getting verbally and physically abused is like a chain of regular event for him. But still he never reported the matter to anyone and always praises their family members in front of outsiders. The only person, with whom he shared all his ups and downs of life and the mal-treatment given by his sons and daughter-in-law is his neighbour Shakeel. He used to spend most of his time with Shakeel. Shakeel always tell him that "if things were not going in a right direction than one must make them right by his/her own efforts. You must take the matter to the police and file a complaint against them". But Ismail denies because of the fear of family status and self respect and hence he never tries to contact police. He has no social life of his own. Further, he spent most of his leisure time in doing prayers and watching Television. He opines that senior citizen who is neglected by their children must be taken care of by the government. The government should make special provisions for them because it is the responsibility of state to repay those who spend their entire life for serving the nation. Although he considers old age as a normal phase of life but he do believes that circumstances makesan individual feeling like a burden or an asset.

Case Study-05

Gul Mohammad;84 years, was a resident of Sir Syed Nagar. Forty years back he came to Aligarh in search of a high salaried job. In 1972, he got into a managerial job in nationalized bank and since then he was living in Aligarh. Presently, he is a retired serviceman and living in the same household where he earlier used to live i.e. during his job. He has two children, one son and one daughter. Son is settled in U.S.A, whereas; daughter was married to a doctor living in the same city. He lost his wife just a year before and was all alone in his house at Aligarh.

Even though after the death of his wife, his son requested him to settle down in U.S.A with his family, but he refused. In order to meet his son and grandchildren; he went to U.S.A every year and spend a month or a two with them and came back. This shows his immense love towards his own place of living. It further shows that his son and daughter are trying their ways to contribute fully in the well-being of their father but are helpless in providing emotional support to him. But Gul Mohammad has no complaints as he said that "I am fully satisfied with the care and love given by my children. I understand their problem and have no complaints". He also committed that in Aligarh he used to miss both his wife and his children. In order to keep him busy; he used to perform various activities like gardening, yoga, morning walk, watching Television and reading books etc. He is also an active member of the old age club of Aligarh.

While describing his health status, he sounds low as he was suffering from many health problems including heart problem, diabetes, Arthritis, and hypertension etc. But still he never showed his careless attitude towards them. He used to take regular medicines and in case of serious problem, he immediately consulted his daughter and son-in-law as both of them were doctors. He has kept one full time female servant to take care of him and his house. She was living with her family in the servant quarter and used to cook food for him and does other needful work. Gul spent most of his time in doing prayers and reading books. It looks as if he was fully satisfied with his life and considers his old age as an 'achievement'. He wanted to live every moment of his life with full energy and enthusiasm. He always gives thanks to almighty for giving him such a nice and caring family. No doubt, he is filled with optimism and zest for life

Case Study- 06

Rukhsana; 64 years, is living in Shanshahbad of Aligarh city. She is living in a joint family having one married son and one unmarried daughter aged 20 years. She came to Aligarh at the time of her marriage. Rukhsana is a house wife and she used to spend most of her time in doing household chores. She didn't get any share in decision making. Nor she had any complaint of it.Financially, she is very poor and her daughter's marriage is her biggest worry. Besides, her husband was bedridden for last few months. She herself was suffering from many health problems like Arthritis and T.B. and which makes herfully dependent on his son for her financial and other expenses. Her son was a labourer and earns only a handful amount. His income was not able to fulfill his all family responsibilities. Due to financial constraints; she stopped the college education of her daughter and many times neglected the required medical treatment of herself as well as of her husband. The only possession she has is the small house in which her family is living. Her son used to force her to sell out the house and give all the money to him for starting his own business. But she always denied and said that "The house is the only place where I can live with peace along with my unmarried and young daughter .How could I put her on road?" As a result of this response; his son and daughter-in-law used to misbehave her and his spouse. They abused her both verbally and physically. But Rukhsana never gives up. This shows her optimistic and courageous nature. She never criticizes anyone for her situation, not even God. She opines that joys and sorrows are like the two sides of a similar coin and one has to think for the ways which turn these sorrows into joys. This positive attitude towards the life makes her feel happy even at the time of difficulties.

Case Study- 07

Mrs. Huma Khan; aged 86 years was living with her spouse and one abnormal son in Sir Syed Nagar. She had one more child who is married and living in Bangalore with his family. He used to visit their parents regularly, send money to them and talk them on a regular basis. Huma came to Aligarh after her marriage and since then she was there in Aligarh. Huma's spouse was bed-ridden for the last four years and she herself was suffering from the problem of Arthritis, Sugar and Osteoporosis. But still she is taking full care of her husband and her abnormal child as she has no one else to look for. She has no financial crunch in her life as she and her husband both were retired as a

Professor from the Central University of Aligarh. Besides, she got many financial assets on her name from the side of her father. She is also having one servant for her help. She spend most of her time in home as she complained that her neighbours used to irritate her by passing comments on her abnormal child and making fun of her. She used to get up early in the morning and take full care of her family and responsibilities. .In addition to the household work, she kept her engaged in prayers, cooking and gardening related activities. Moreover, she used to take part in some social events. Presently, she is holding the post of a President in some Women's Association in Aligarh. She was also helping many poor families by providing financial assistance to them. Further, she is giving financial assistance to a school for providing free and quality education to girls belonging to poor households. Thus for her consistent efforts, she has been awarded many prizes by the voluntary agencies and local bodies. Even though her husband and son were both ill and she is facing many problems out of that; but still she never gave up. Her active participation in various activities shows that she is very courageous and has taken life positively.

Case Study- 08

Smt. Neha Kashyap; 63 years old, is living with her husband in a rented house. She is a housewife and her husband is presently not working anywhere. The financial expenses of her family were shared by their elder brother who is residing in the same city. Neha had only one son who is married and settled in Delhi. But his income was not sufficient to support his father's financial responsibility. In order to provide some financial help to her family, Neha used to sew clothes of her neighbours. In addition, she spends her time in cooking, watching Television and going for a walk. She has no major health problem except the Cataract which is going to get operated very soon.

Neha and her husband are very social as they never missed any chance of visiting their relatives and neighbours. She is also having deep faith in religion as she used to visit the nearest temple on every morning. This can be further realized from the fact that during the whole conversation she kept on moving the beads. She always started her day with morning prayers and took part in different religious functions. She wants to become a Social Worker for serving the society. She always tries to help people in whatever way is possible. She has an artist lying within him and composed many poems and folk songs. She always holds a positive attitude towards her life. She doesn't consider

herself as old as she is actively involved in all the activities which she earlier used to do. She has no problems in the family and in doing household chores. Her husband is very supportive and caring. But dependency on someone else for running the family makes her feel depressive. She opines that old age requires support and care from the family and especially from the siblings. Further, she holds the view that Old Age Home is not the right solution of the problem of senior citizens.

Case Study- 09

Mr. Jagatram; 94 years old, is living in a joint family including two married sons and their families. He lost his wife in an accident three years back. His daughters got married in different countries and very rarely they got time to visit him. His sons were busy with their own families and personal engagements. Hence, theytoo had little interaction with him. He is retired from a class one government job. After his retirement, he has started a business of cloths just to get engaged somewhere. Financially, he is very sound as he possesses the ownership of one petrol pump, two hotels, one nursing home; two flats and some farming land. Although he has a lot of money but still he spend a simple life wearing Kurta Paijama and taking simple food. He is known for his kind heartedness as he always helps those who are in need. Besides, he used to donate some amount to temple's trust for noble reasons.

He is very close to her granddaughter who is ten years old and spends his spare time with her. He also indulges himself in various kinds of activities. Even though he turned ninety four but his social life is still very active. He is a member of many social and religious organizations. He has been invited as a guest by many organizations for sharing his valuable experiences. In actual, he is the 'role model' for his age group. This shows that there is no barrier of age in social interactions. He does all his activities of daily living by his own. He used to get up early in the morning, have a morning walk, do exercise, indulge in morning prayers and then started his daily routine. He spent his leisure time in reading books, watching television, playing chess and cards with her granddaughter. He is also having good health as he has no major ailments, except sugar, arthritis and cataract.

For him, old age is not a time to repent, but a time to enjoy one's freedom. He is very optimistic and practical. He used to warn his children to remain sincere and motivated towards their work and keep human values alive in them; otherwise, he will transfer all

his property to the trust. He wanted them to develop a vision towards their life and do something for the upliftment of weaker and vulnerable sections. This all shows that an aged person can also live his life in his own way; if he wishes to do so. No one, even the increasing age, stopped him from doing that.

Case Study- 10

Mr. Om Prakash Joshi; 82 years is living alone. He is basically from Kashmir. At the age of 12 years, he ran from his home so that he can make money and earn some name and fame. It was about 70 summers that he spent in Aligarh. Since then he never turned back to his family. He was all alone in Aligarh as he is single. His accommodation wasa thatched house with poor sanitation. He was a rag picker by profession and earns a very little sum of money. In the name of financial assets; he possesses two-three utensils, two set of clothes and one blanket. Thus, he is living in very adverse conditions. The street children used to make fun of him and tease him, but he never replied. On looking into his pathetic situation, his neighbours used to feed him. The ward member also helped him in getting Old Age Pension (OAP) and since last one year he was getting it. As the amount of OAP is not sufficient in fulfilling his basic requirements, it was difficult for him to sustain his normal life. He is looking for an opportunity to shift to an old age home where he can get a day's meal without tension. But due to unawareness, he didn't make any such arrangements.

He is also suffering from many health problems such as Arthritis, hearing loss, vision problem and short-term memory loss. Due to financial instability, he was not in a condition to start his proper medical treatment. In these days, he is missing his near ones and wants to go back. But the fear of getting unfavorable response and unavailability of funds makes him feel helpless. All these ups and downs make him feel like a burden on the society. He is fed up with his life and counting his days of death. He thought that government must provide some kind of assistance to people like him so that they may not turn out to be a burden.

Case Study- 11

Smt. Ritu Devi is a resident of Hamdard nagar. She is 68 years old and is belonging to a Schedule Caste family. She came to Aligarh after her marriage. She is living in a nuclear family and has got four sons and two daughters. Out of them, both her

daughters and two sons were married. His married daughters are living in the same city and they used to meet their parents once or twice in a month. The married sons are also living in the same city but had separate households in the same locality. They didn't provide any kind of help to their parents. They separated just because of family conflicts related to financial crisis. The remaining two unmarried sons are residing with them. Her husband was under the treatment of T.B. and did not earn a single penny. Hence, as an income generation source; Ritu and her two unmarried sons used to work in the lock firm as daily wager. But the money they earn is not sufficient in bringing a quality of life to them. Due to financial crisis; Ritu Devi did not even provide proper education to her children. She only provided them with the nearest primary school education.

Presently, her family is living in very scary conditions as they don't have any water resources available within their house. They used to fill water from public hand pumps. Moreover, they had no toilet of their own and used public toilets; house was semi-pucca in nature with having single room. Their financial problem also makes an impact on their dietary intake. They were not getting balanced diet. Hence, Life to them is just a passing up of days and a miserable experience. Many times she thought of applying for Old Age Pension but unfortunately, she did not get. This is because of her dependency on someone else for making application. This all makes her feel depressed and isolated.

Although Ritu does not believe that her woes will end by simply doing pooja and citing religious hymns but even she visited temple once or twice in a month. Her most of the time was utilized in doing household jobs. Till sunrise to sunset, she didn't get even a single minute for relaxation. Sometimes she didn't even take proper sleep as she has to look after her husband. These engagements were deteriorating her health as well. It also makes her feel irritated and short tempered sometimes. She believed that her miseries had no end and considers her old age as the worst phase of life as it makes her totally helpless.

Case Study- 12

Mr. Habeeb Kamal; 78 years, was born and brought up in Aligarh. He belongs to a middle class family and was totally illiterate. He has four sons and two daughters all of them were married. He is living with his wife and his sons are living near him in the same locality. His daughters are also married in nearby cities. The old man is not

physically fit and is not in a position to walk. His illness makes him feel weaker and dependent. But he is fortunate enough to have a caring wife who used to take full care of him in both the day and night. She also helped him in doing all his Activities of Daily Living. Financially, he is very sound as he possessed a large piece of agricultural land. Each of his sons wants to take custody over his property. This may even introduced quarrel amongst the children. For getting the custody; sometimes they offered co-residence to their parents whereas, on the next moment they started shouting and using abusive language. One day they even started beating their parents in front of others. That is why they were living alone despite of having four children. He told that "after seeing my children fighting like animals, I used to felt helpless and would like to end my life now". Therefore, he wanted to convert his property into a trust for the purpose of helping those whose children used to neglect them and do not havetime to them. At this stage, he is also suffering from many health problems such as arthritis; hypertension and heart disease. The old man always lives in distress and feels neglected. He spent his leisure time in having a walk of his wife; doing prayers and watching T.V. He even reduces his social contacts which he earlier used to have. For him, old age is a painful experience, a period of neglect and isolation.

Case Study- 13

Rehana, 65 years old is living alone in Shahanshabad. She is the single child in her family and at the age of 22 years, her mother and father were found dead in a car accident. After that their relatives and family friends forced her to get married so that she can forget this sad incidence and get a chance to live life. But destiny has decided something else for her as the family in which she was married is very money minded. They became ready to marry their son to her for just grabbing her parental property. Just after her marriage, they demanded her to sell her whole parental property and on her denial; they started abusing her both physically and socially. Within two years of her marriage, she got divorced from his husband. She was then shifted to her maternal aunt's house where she was put to work like anything. Her aunt's children also used abusive language for her. She has no one to share her feelings except one living near her house with which she shared her problems. Unfortunately, she has shifted to her son's house living in different city leaving her feel all alone. As a result, Rehana reduces her social contacts and kept herself isolated. In order to keep herself busy and getting some favourable earning; she opened a vocational training centre for girls in her locality

where she used to teach sewing, painting and other related activities to young girls of her society. This will bring some earning along with some sense of social satisfaction. Rest of the time she kept herself busy in doing some prayers and doing household jobs. Since, she belongs to the younger-old age group she is not affected by any major health problem except the minor losses in vision. But psychologically; she is very much disturbed. She is afraid of the day when she turns more older and need someone else for help. This was actually the worry of almost all those aged who are lonely and had no support of any kind.

Case Study- 14

Mr. Sikander Rao; 87 years, is living with his wife in a nuclear family in Aligarh. He was retired from police as the post of District Superintendent. Even after so many years of his retirement he was invited by senior officials for consultation. This makes him feel relaxed and comfortable. After living a disciplined life, he has nothing much to do and thus he preferred himself to stay in home. He has two sons. Elder one is settled in Bangalore at the post of Assistant Engineer and second one is a doctor practicing in Jaipur. Both his sons are married and are in a regular contact with him. They used to give telephonic calls daily and come to meet their parents after every three or four months. Mr. Rao loved his wife very much and wanted to fill her life with joy and happiness. Presently, she is suffering from heart problem and was operated in Escorts, New Delhi. He spent almost all his savings on her treatment. He himself was facing many health problems including diabetes, arthritis and hypertension. He is a very kind hearted individual and always remains ready to help people in need. For instance, he and his friends were making a trust with whom they are helping the school children who are not in a condition to pay. He spent his leisure time in walking; reading books, watching television and visiting public places. He has a wide knowledge of the basic concepts of life and its wider happenings. He always tries to motivate and empower people through his discussions. Old age to him is merely an increase in the number of years. He also initiated an elder people's club in his locality where older people used to come and share their experiences and where the elderly people feel relaxed and enjoyed their old age. He even tries to arrange few lectures of officials in his elderly club so that the community people get suitable information regarding various issues. In short, he is enjoying his old age with a positive attitude towards life.

Case Study-15

Mr. Arun; 71 year old, is a famous lawyer of Aligarh. He came to Aligarh with his father. His father was a government servant and was shifted to Aligarh on a transfer basis. His father found Aligarh as more suitable place for the education of his children and hence he decided to settle down in Aligarh. Since then Mr. Arun was residing in Aligarh. In his family, he has two sons and two daughters. One year prior, he lost his wife. Besides, he had two daughters both married in the reputed families of Agra, whereas, the sons are living with him in the same parental house. The elder son is married and used to help his father in doing legal practices whereas the younger one is in studies. Financially, he is sound as he is among the famous lawyer of cities and charges about fifty thousand or more for a single case. In addition, he has many acres of agricultural land on his name. Along with social life, Arun is very active in making social contacts. To keep him busy, he used to spend most of his time in doing his official work. This also helps him in forgetting his wife and getting isolated. He is also a religious kind of man as he never missed his morning prayer, reading of Ramayana and Hanuman Chalisa and lighting up of lamp before his kuldevi.

He is in a habit of taking good care of his health as well as he used to go for a morning walk, have regular exercises, health checkups, takes low fat diet and nutritive health drinks. This makes him healthy even in the age of 71 years. He enjoyed spending some time with his only granddaughter. He used to share his food with her. His other leisure time activities include reading books, net-surfing, writing blogs and having discussions with people on the leading topics of the country. Old age to him is an achievement. He opines that senior citizens should have the knowledge of rules and schemes of the government meant for their welfare and also have the awareness about their rights. He opines that old age will no longer remain a problem unless one has planned his old age and keeps some saving accordingly. This shows thatpeople having higher education and high social status knows the importance of their experience and they try to utilize it whereas those who had no resources of income and had no education considered them as a burden.

Discussions

In order to support the study with some qualitative data, fifteen case studies have been conducted. The Qualitative framework was chosen because the researcher does not want to get confined with the limited questions of interview schedule; identifying the socio-economic and health profile only. The analysis of these case studies brings some interesting findings:

First and foremost is the need of financial independence in old age. The case studies highlighted that in old age financial security plays an important role as it was found that the people who are financially sound are enjoying their old age more as compared to the others. For them, old age is a period of freedom from responsibilities. They further considered their life as an 'achievement' rather than a 'burden' or 'curse'. This can be easily seen in the case of Mr. Arun, a famous lawyer,71 year old, Mr. Jagatram; 94 years old and Mr. Sikander Rao of 87 years. They all are fully satisfied with their life and always try to motivate others. Old age to them is merely an increase in the number of years. For example, Sikander Rao started an evening club for senior citizens in his own locality where older persons of his own locality used to come and share their valuable experiences, joys, sorrows, emotions and many more things. Further it brings some time for relaxation to them and makes them feel energetic. Similarly, Smt. Ritu Devi, a resident of Hamdard nagar is now 68 years old and belongs to a Scheduled Caste family. Her financial condition is very poor because of which she used to feel depressed and isolated sometimes. She considers her old age as the worst phase of her life as it makes her feel totally dependent and helpless. Thus, financial security in old age is a must.

But getting financial dependence is not sufficient for healthy ageing as is the case of Mr. Habeeb Kamal; 78 years old, living separately from his sons who are living in the same locality. For him, old age is a painful experience: a period of neglect and isolation, because he holds some parental property on his name and because of which his four sons always quarrel with him to get possession. Thus along with financial security, there is needed some social support, respect of relations and love from near ones. Otherwise, old age cannot be enjoyed.

Rukhsana; 64 years, is living in Shanshahbad of Aligarh city. She is living in a joint family having one married son and one unmarried daughter aged 20 years. Financially,

she is very poor. In addition, her husband was ill and was bedridden since last few months. She herself was also suffering from many health problems like Arthritis and kidney failure. Her daughter's marriage is her biggest worry. But still she filled her life with courage. She never cursed anyone for her situation and thought that someday God will overcome all her difficulties. This positive belief kept her always happy and especially at the time of difficulties.

In old age; marital status also plays a significant role in curbing the feeling of loneliness. In case of high income groups social networks are generally limited to household only and in that case the presence of spouse makes one feel easier, relaxed and with less stressors. Same has been reported in the case of Mr. Sadaqat Hussain who was a resident of Sir Syed Nagar and has lost his wife. He reported that despite all his efforts to make him engaged; he used to felt lonely many times. This is because he was very close to his wife and always misses her. He filled his eyes with tears while describing his wife.

In addition to all these problems, the saying 'Health is wealth' is found more applicable in case of senior citizens. Many of the senior citizens have reported health as their biggest worry as bad health adds woes to their problems. Further, it makes them dependent and physically weak. It also reduces their earning capacity. Similar problem was reflected in the case of Sikander Rao and Habeeb Kamal.

Hence, from the above findings it can be concluded that old age is a period of life which can be made normal or troublesome depending upon the individual's frame of reference and prior preparation. If one plans his old age thoroughly; he would never be in crisis and will enjoy his old age like he enjoys the other phases of life. But those who entered old age without any prior preparation will definitely experience some kind of troubles in old age and for them life turned out to be a curse.

The analysis of above case studies also reflected few interesting findings: First, Senior citizens belonging to lower income group or are totally dependent considers their old age as a 'curse', whereas , those belonging to higher income group or are able to do their activities of daily living are still enjoying their old age. For them, old age is a period of freedom from responsibilities whereas other considers it as a period of struggle. Second; senior citizens, irrespective of their income, preferred living in their own home and with their close ones rather than living in any old age home. Third,

health is the most common sector which affects almost every senior citizen and hence needs special concern and focused interventions. What is needed the most is the attitudinal change towards the aged. Once the senior citizens started feeling their importance in the family and society, they started enjoying their life. For this, all the stakeholders including the media, younger generation, the educational institutes, the NGOs, the policy makers, the politicians and the bureaucrats; all needs to join hands and work in a positive direction towards making the old age successful and healthy.

CHAPTER IV

CONCLUSION
&
SUGGESTIONS

CONCLUSION AND SUGGESTIONS

Ageing is a universal phenomenon. On the global level, the phenomenon of ageing was first highlighted in 1982 when the United Nations organized the first World Assembly on ageing in Vienna. Since then, ageing population is not only the sole concern of developed countries; rather it becomes a critical policy issue in developing World as well. There is no escape to ageing; however, different countries are facing its impact differently based on their socio-cultural and economic characteristics. The Projections of the United Nations Population Division showed a massive demographic shift being taking place in both the developed and developing countries. For instance, the population aged sixty and above in the developed countries will projected to see the percentage of the old people in their population rise from an average of seven percent to over eleven percent by the year 2015.China and India, alone accounts for over fifty percent of the elderly in the less developed regions.

Presently, the developing countries are not emphasizing much on ageing and related problems as compared to the developed World. This is because the problem is not seen as serious in developing countries as compared to the developed nations. But in years to come, it will definitely throw some serious challenges to developing nations and especially to India as because of having the larger share of younger generation at present. India is also heading towards the similar demographic pattern like others. Today every sixth person in the World is an Indian and every fifteenth Indian is likely to be an older person. The population of older persons in India ranks fourth highest in the World and by the end of the present century it will be second only to China.

According to an estimate there are at present 76 million aged persons in the country. Thus India can not only boast of being the highly populous country, it can also claim a place among the "Aging nations". The U.N has already declared India to be an "ageing society" where the aged accounts for more than seven percent of the total population of the World. Thus to experience 'Delayed and Healthy ageing' understanding of the implications of population ageing is must. In fact, this is the right time to think for these missing dimensions both at the micro and macro level. At the micro level, it implies the ways in which person adopt their lives to the important transitions that occur across the life course. It also implies coping with new issues arising from the adjustment on the part of the indivtduals. At the macro-level, it

implies the challenges of growing ageing population based on the economy, education, health, family and welfare concerns of a nation. It impacts on family structures and individual life-styles which, in turn, influence the quality of life of the elderly. In a nutshell, it becomes imperative to look into the various aspects of their social, economic, psychological and emotional problems.

The present study is a minor initiative in the field of ageing research to identify the needs and socio-economic problems of senior citizens in an urban context. It further outlines the coping practices as required for coming out of these socio-economic problems. Hence, the focus of the study was on both: the problem identification as well as on problem solving which further puts this study under the domain of Social Work.

The study basically focuses on the senior citizens of Aligarh city of U.P. The basic purpose of research is not merely identification and description, but also prediction and control of the problem in the present context. In this light, the present study was a modest attempt to understand socio-economic and health problems among the elderly along with their possible interventions. The study in hand is entitled as **"A study on identification of socio-economic problems, coping practices and possible interventions for senior citizens of Aligarh (U.P.)".** Keeping this broader objective in mind the following research objectives have been formulated:

- To study the socio-economic profile of senior citizens of Aligarh city.
- To identify the socio-economic and health problems observed by the senior citizens of Aligarh.
- To analyze the coping practices adopted by senior citizens in coping with their socio- economic and health problems.
- To suggest interventions in dealing with the problems as identified in the present study.

'Diagnostic cum Descriptive' research design was adopted to realize the above objectives. The data for present study was collected from both the primary as well as secondary data. For primary data, interview schedule and case study method was adopted , whereas various journals, refereed books, articles, magazines and websites were scanned for locating studies relevant to the topic under study. This exercise helped not only in finding gaps in the studies but also helps in developing better

comprehension about different dimensions of the present study. Further, the Chi-Square test of significance was applied to test the association between background characteristics of respondents and socio-economic problems. Inferences were drawn from the statistical findings so arrived. Some important findings emerged from the analysis of statistical data which are discussed as follows:

First is the age-wise distribution of respondent covered under the study. The findings reveals that majority of respondents (54 percent) falls within the age group of young-old (60-69 years) followed by the old-old (70-79 years) 32.8 percent and the oldest-old (80+) 13.2 percent age group respectively. This shows that the sample covers senior citizens of almost all age groups falling within the different age categories. In addition, the composition of male and female respondents was found to be almost similar as it includes 50.6 percent males and 49.6 percent females respectively.

In order to study the age-specific gender differences, the gender-wise composition of respondents within the three age categories, namely, young-old, old-old and the oldest-old has been determined. The findings reveal that females outnumber males in the oldest-old age group which in turn indicates the vulnerability of oldest-old female elderly as it raises their chances of widowhood and financial dependence. These results go substantially in line with the observations of P. S. Anklesaria et.al.

In order to check the impact of religion on the life style and coping practices of senior citizens; religion as a variable has been introduced. The findings reveal that majority of respondents were Muslims (280) followed by Hindus (220).There was no respondent belonging to any other religious community. This shows the dominance of two religions in the sample. The above findings also matches with the religious distribution of the total population of Aligarh (Census,2011) which shows 81.49 percent share of Hindus followed by 17.78 percent Muslims and 0.73 percent population following other religions(e.g. Sikhism and Christianity).

Education directly affects an individual's source of earning. Hence, an attempt has been made to diagnose the educational status of the respondents. Further the education is responsible for bringing improvement in the Quality of Life of respondents. The present study assumes that higher the level of education better will be his/her standard of living. The findings clearly reflects that although majority of respondents 327 (65.40 percent) were literate, but they were educated only up to

primary or secondary level (40.6 percent). For instance, there were 76 respondents (15.2 percent) who were educated till primary level, followed by 48 respondents (9.6 percent) till middle class, 59(11.8 percent) till high school and remaining 20(4.0 percent) respondents till the level of Intermediate. In addition, 12.8 percent respondents were totally illiterate. However, the percentage of respondents who were holding some higher degree was also significant i.e. 46.6 percent. Out of them, graduate and post graduate degree holders were 6.8 and 7.0 percent respectively. Besides, 29 respondents (7.0 percent) hold some professional degree (e.g. B. Tech, M. Tech, M.B.A, LL.B etc.) and about one-fourth (25.8 percent) of the respondents were holding the degrees of Ph.D or D.Lit. This shows that the sample comprises of a good mix of respondents holding lower as well as higher education.

Along with education, the present study also assigned an equal weight age to the marital status of respondents because imperative roles and responsibilities have been assigned to an individual on the basis of his/her marital status. Marital status is also important in case of determining the care giving and social interaction experienced by the elder generation. The present study reflects that majority of senior citizens (66.2 percent) were married and used to live with their spouse. This was followed by the number of widow/widower (32.2 percent).

It was further observed that higher percentage of married and living together respondents were from 'young-old' and 'old-old' age groups, whereas, majority of widow and widower belongs to the 'oldest-old' age category. This finding therefore suggests that with increase in age, the chances of living together with spouse decreases, hence increases the problem of care giving and social isolation.

In old age, care receiving and pattern of social interaction also depends upon the type and nature of family in which the respondents used to live. In the present study, the family has been classified into two broad categories, namely, nuclear and joint. Nuclear family is one where an aged person stays with his/her spouse and/or unmarried children or is living alone in a single household, whereas, joint family is one where the senior citizens are living together with their spouse and married children and grandchildren. The finding clearly reflects that overwhelming majority of respondents 280 (56 percent) were living in a joint family, whereas, remaining 280 (44 percent) respondents preferred living in nuclear families. The prevalence of joint

family over nuclear clearly reflects the fact that Aligarh is a traditional city which carries its own values and societal obligations of respecting elders. Hence, care receiving is not an issue for the senior citizens of Aligarh.

But the rapid pace of urbanization and better employment opportunities available outside the city has initiated the process of migration in the city. In old age, migration to any unfamiliar place becomes a social threat , as migration affects the life of senior citizens in many ways e.g. it develops the feeling of isolation and boredom, puts elderly into stress and depression and reduces their level of confidence. It also affects their eating habits, social and psychological health. In the present study, there is found no such impact of migration in the life of elderly as out of 500 respondents, only 63(12.6 percent) had reported their shift to the city within the spell of last ten years, whereas, 435 (87.0 percent) respondents had never face such problem as they were either born in Aligarh or had shifted many years back.

Out of the small number of the cases of migration; the reasons as to why the respondents migrated were also studied and the reasons found were the retirement from work, considering Aligarh as a nice place to live in, employment of children in Aligarh and their financial dependence on them, loneliness due to the death of spouse, treatment of their chronic illnesses, shifted after communal riots etc. Findings also indicate the problems associated with migration of senior citizens. Out of those who migrated (63 respondents); 'adjustment' was found to be the most frequent problem observed by the majority followed by the problem of loneliness and reduced social interaction.

Moreover, the size of family and the proximal distance of children were studied in order to determine the extent of care giving available during old age. Size of family is related to the savings and probability of care received by the elders. Those with less income and larger family size were facing economic hardship. The findings reveal that majority of respondents 197 (39.4 percent) were living in a medium size family (having members between three to six) followed by 130 respondents (26 percent) residing in small family (husband-wife only). However, 92 respondents (18.4 percent) belong to the category of 'larger' family size (between seven to nine) and a significant number; 57 respondents (11.4 percent) belong to 'very large' family size (i.e. above 10). There were only 24 (4.8 percent) respondents who were living alone.

The findings also reveal that overwhelming majority of respondents 403 (80.6percent) had at least one of their children living near them or within the same city to take care of the respondents. Out of remaining; 46 (9.2 percent) respondents had their children living in different cities, 41(8.2 percent) had children settled abroad and only 10 (2 percent) had no siblings. This clearly suggests that overwhelming majority of respondents 476 (95.2 percent) had at least someone to look for. Hence, they do not need any formal type of formal care giving. The only need is to motivate the family as a caregiver.

In the present study, 'Housing condition' was also introduced to know the financial and health status of the respondents. For the sake of simplicity, the housing conditions have been classified into three categories as poor, average and good. The poor housing is one where total sanitation is absent, there was no drainage system, no toilet and bathing facility within their house premises and houses were even Kutcha i.e. made of straw, tin, and mud etc. An average house means semi-pucca house with one or two rooms along with toilet and bathing facility available inside the house. But the drainage system was not proper. In contrast, the good housing includes the well furnished pucca houses with three to five rooms, hygienic toilets; bathrooms and good drainage system. The findings reveal that overwhelming majority of respondents (70.20 percent) were living in good housing conditions followed by average houses (17.6 percent) and poor housing (12.2 percent) respectively. In terms of financial status; it was found that generally the labour class is living in poor or average houses whereas the middle and high income groups enjoyed living in pucca houses equipped with all modern facilities.

Along with housing, elderly needs some privacy. In old age, the people want to do their work in their own ways and that too without mood swings. They required private space for doing their Activities of Daily Living e.g. for doing prayers, taking rest, watching T.V. and for chatting with peers etc. The findings indicates that majority of respondents 313 (62.6 percent) had got a separate room for performing their personal activities, whereas, a significant number of respondents 187 (37.4 percent) either shared their room with someone else (other than spouse) or lives in Veranda, lobby or in some common place. Further, it was found that those who were living in nuclear families and had a good source of income were all having privacy whereas, those who were belonging to larger families and had lower income were generally shifted to

shared and congested spaces. Hence, in joint families the senior citizens got social security but the extent to get privacy reduces, whereas, in nuclear families they generally face the problem of social isolation and loneliness. Further, in joint family; they generally face the problem of disrespect and lack of privacy, whereas in nuclear family they hold the decision making power and experienced the problem of care giving. Therefore, respondents belonging to any of the socio-economic class, they had their own problems and needs.

Since the study aims at identifying the socio-economic problems of senior citizens, many problems were identified in this regard. Loneliness is found to be one such problem. The present findings indicate that almost all respondents felt loneliness in old age. However, the intensity and reasons of getting lonely may varies. For example, there were 368 respondents (73.6 percent) experiencing loneliness sometimes, whereas, 132 respondents (26.4 percent) felt loneliness always. The reasons they cited for feeling loneliness were their spouse's death, children's indifferent attitude towards them and the poor health status.

In old age, the senior citizens do have a plenty of spare time and spending that in a favourable manner is a biggest challenge. The findings revealed that majority of respondents used to spend their leisure time in non fruitful activities e.g. 323 (64.6 percent) respondents spend their leisure time in gossiping, 275 (55.0 percent) in watching T.V. and listening radio, 179 (35.8 percent) in pursuing religious cults, 166 (33.2 percent) in doing household jobs, and 108 respondents (21.6 percent) in doing grand parenting. However, a very few respondents 42 (8.4 percent) showed their interest in other gainful activities including gardening and joining senior citizens club, participation in social and political events 56 (11.2 percent) respondent, visiting public places 124 (24.8 percent) respondents etc. The findings further highlighted that the respondents belonging to middle and higher income group generally adopt playing (68 respondents; 13.6 percent) and reading 82 respondents (16.4 percent) as their favourite time pass.

Moreover, the reasons behind the improper utilization of leisure time were studied. The respondents complaint of having lack of facilities, improper channels of communications and physical and financial dependence etc as the basic reasons behind the follow up of leisure activity. They reported that Leisure activities in which

they were indulged were generally based on forced choices. Hence, they were either partially satisfied or totally dissatisfied with the leisure time activities. In this regard, the findings reveals that almost half of the respondents 249 (49.8 percent) were partially satisfied, whereas, 119 (23.8 percent) respondents were not satisfied with their activities of living. However, only 132 (26.4 percent) respondents were fully satisfied with their leisure time activities. Those who were fully satisfied belong to higher income group and to the young-old age group. This shows that the majority of respondents were not having facilities to choose their preferred life style. Hence, need is to provide for more fruitful ways of passing leisure time for the elderly.

Another significant variable linked to the socio-economic problems of senior citizens is the social status. Social status plays a significant role in the life of senior citizens as it not only affects their social position but also determines their mental and psychological well being. The present study indicates that a large number of respondents (55.2 percent) shared the same position within their family as they earlier used to share. However, a very small percentage (10.2 percent) reported that their social status has enhanced in old age. Those who reported increase are mostly belonging to higher income groups. However, almost one-third of the respondents (34.6 percent) reported decline in their social status. This was due to their poor health and financial dependency. They were generally belonging to the oldest-old age category. This shows that with increase in age and with more financial dependence, the social status generally declines.

Another component affecting the social position is the decision making power. The findings reveals that 47.2 percent respondents had shifted their decision making power to someone else. However, 264 (52.8 percent) respondents were still in a position to take decisions. On getting specific into the area where they used to take decisions it was found that out of 264 decision makers; 56 percent takes decision in financial matters, 71 percent in the matter of marriage and children's education, 46 percent in household work and 83 percent in matters related to religious activities etc. The majority showing its share in decision making is just because of the traditional practice of giving love and respect to their parents. This shows that although Aligarh is in a rapid pace of urbanization but its' cultural practices are still pertinent.

The findings of R.K. Punia et.al. in Hissar also supported the present observations and highlighted that 74 percent urban and 65 percent rural elderly were still treated as the head of their family. P. Mohanan et.al and S.Kaur and M. Kaur observes that majority of senior citizens enjoyed authority in making familial decisions and had no share in decision making in financial and other important issues.

In another study by Tulika Sen in Calcutta, the impact of 'gender' as a variable in taking familial decision was analyzed. The findings revealed that in rural areas, males play a dominating role in financial management (55 percent males), whereas, females (59 percent) play significant role in religious activities. In addition, the study of M. Jain and A. Sharma found that half of the aged men were consulted for matter related to education, festival, and social ceremony; three-fourth for marriage, land and property matters, 20 percent for societal work, 83.23 percent for occupational matters and remaining 36.6 percent participated in social activities. However, female's opinion was sought for social functions and religion based activities only. Similar is the findings of present study as in most of the cases females are not involved in decision making (143 females) whereas, males (160 respondents) participation is more. However, females (104) who have reported their involvement in decision-making also complaint of having partial share i.e. they got involved in the discussions only but had given no choice to alter or take final decision.

In the present study the reasons for lost in decision making power was diagnosed. The findings suggest that those who lost their share either belong to oldest-old age group or gets financially dependent on family members. However, those who are living in nuclear families and belong to higher income group are the decision makers of their own affairs. S.K. Ghosh and Maulik in their study based on identification of family authority in old age depicted education, death of spouse and age of respondent as responsible for making decision in old age. For instance, the findings reveal that 82.44 percent urban and 73.14 percent rural aged were retaining authority in the family up to the age of 64 years only. Moreover, with the death of spouse only 26.4 percent rural and 42.1 percent urban retained their family authority.

This shows that the problems of senior citizens are interconnected. For instance, the problem of elder abuse is somewhat related to decline in social status. Elder abuse although is more prevalent but elderly considered it as a sign of disrespect and decline

in their social status and hence they hesitate in reporting abuse. The more severe the form of abuse, the least reported the case would be. Similarly in the present study, majority of senior citizens 350 (70 percent) denied to have any form of abuse. Out of remaining, 17.2 percent reported the cases of verbal abuse, 7.6 percent reported emotional abuse and neglect, whereas, a very small percentage of respondents 26 (5.2 percent) reported physical abuse. Similar findings have been reported by U. Bambawale in Pune, A.M. Khanin in Delhi and R.K. Punia et.al while comparing ageing problems among rural-urban areas and A. K. Panda in M.P. Hence, from above findings it can be concluded that elder abuse is very common phenomenon of present.

In case of abusers, family members were found to be the most frequent abusers or the primary abusers of elderly generation. The present study also reveals that out of the total number of reported cases of abuse; primary abuser was their son (56 percent) followed by daughter-in-law (29.34 percent), spouse (7.34 percent) and daughter (0.66 percent) respectively. This shows that senior citizens generally shared more healthy relations with their daughters and spouse as compared to their son and daughter-in-law.

In case of reporting of the cases of elder abuse, it was found that seventy respondents (14 percent) had never reported the case of abuse to any one, not even to their spouse. However, 28 respondents (5.6 percent) discussed it with their friends, 5.0 percent discussed it with spouse, 3.0 percent with neighbours, 1.8 percent with other family members and 0.6 percent with relatives. The reasons they cited for non-reporting of the cases of elder abuse were the maintenance of family honour and self respect and financial and physical dependency on others etc. In this regard, Shubha Soneja in her country report for W.H.O. outlined lack of emotional support, neglect by family members, and feeling of insecurity, loss of dignity, maltreatment and disrespect by the family members as the common forms of abuse experienced by the senior citizens.

But the basic problem with elder abuse lies in the recognition of these acts as abuse because the elderly person did not recognize these acts as abuse and linked it to only severe acts of violence e.g. battering and throwing out of house. Thus, it can be concluded that elder abuse is something which is more prominent but least reported phenomenon which needs more awareness and sensitization.

In old age, elder abuse also brings the feelings of disrespect and loss of self esteem. Elderly on getting abused from their family started feeling isolation and loss of self esteem. Thus identifying coping ways to combat abuse is a much needed intervention. In this regard, an attempt has been made to identify the coping practices adopted by the senior citizens themselves. For sake of simplicity, these have been classified into Emotion Focused Coping and Problem Focused Coping. The findings revealed that majority of respondents 379 (75.8 percent) adopted Emotion focused coping in case of disrespect and abuse. However, the problem focused coping was adopted by only one-fourth of the respondents (24.2 percent). The findings also revealed that the respondents in the age group of old-old (70 to 80 years) and oldest-old (80 plus) mostly followed emotion focused coping, whereas, problem focused coping was adopted by the young-olds (60 to 70 years) only. This pattern shows that with advancement of age, the practice of adopting emotion focused coping increased.

While looking into other alternatives through which the senior citizens can cope effectively against the psychological and emotional problems; Susan L. Hutchinson et.al reported that joining any social group e.g. Red Hat society may serve as an effective strategy for coping as it provides social support, emotional regulation, sustaining coping efforts and meaning focused coping rather than emotion focused coping. Similarly, E. Gunnarsson[1] in his study carried out in Sweden and on the 'oldest-old' age group reported that both men and women respondents pointed towards the need of being active; positive thinker, remaining stress free and not good to take things easier as some of the qualities required in maintaining the self-esteem.

In this regard, religion was found to be as another alternative; as in old age people develop more faith in God. They even opted for religious practices as a means of coping against distress. Out of 500 respondents; almost half of the respondents 229 (45.8 percent) were using religion as a means of coping against psychological and emotional problems, whereas, 144 (28.8 percent) respondents followed it sometimes. Remaining one-fourth of the respondents (127) were not in a habit of adopting religion as a means of coping, however, they too had deep faith in God.

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1 Gunnarsson, Evy. (2009). *I think I have had a good life: the everyday lives of older women and Men from a life course perspective.* In journal Ageing and Society: Cambridge University Press.Vol.29. No.1. Jan. Issue. p.41.

These people commented that religion is for the peace of mind and if they want to get out of some problems than their hard work will pay and not the prayers. In this regard, P.K. Muttagi also identified the practice of religion as a common trend among the aged men and women. He further reported that the senior citizens were using religion as a weapon against the management of psychological stress, alienation and loneliness. This all shows that religion is also playing a significant role in coping with difficult life-situations especially at the time of distress, psychological and emotional problems.

Media can also be used as an effective strategy for improving the quality of life of elderly as everyone is connected with media today. Keeping this in mind, the opinion of senior citizens regarding the role of media in reducing the intergenerational gap between the aged and the younger generation has also been identified. The findings revealed that majority of respondents179 (35.8 percent) holds the view that media is responsible for enhancing the generation gap. However, 100 (20.0 percent) respondents believed that it all depends on an individual that how he takes the things. On the other hand, there were 35 (7.0 percent) respondents who believed that media has no role in either enhancing or reducing the intergenerational gap. For remaining 142 (28.4 percent) respondents, the question has no significance as they don't have regular access to media. In addition, they were either illiterate, financially poor or were physically dependent.

Next alternative in providing effective life styles to the aged is to make them separate from their family members and provide all essential facilities to them. Government has made many efforts in this regard in terms of old age homes. But the problem lies in the psyche of individuals as they consider Old Age Home as a symbol of isolation, neglect, and deprivation. In the present study, an attempt has been made to understand the perception of respondents regarding the living of themselves and that of the dependent elderly in Old Age Homes. Do they prefer living in old age home over their present living or think that some other alternative may work more effectively instead of living in old age homes? The findings revealed that a large number of respondens 413 (82.60 percent) considered old age home as the right place for needy and dependent elderly. However, 85 respondents (17 percent) considered it as a wrong choice as nobody wants to get separated from their family. However, a very small percentage (0.40 percent) did not respond to these questions as they had no idea of

living in old age homes. In contrast, a large majority, 469 respondents (93.80 percent) totally denied their living in old age homes, whereas, twenty-nine respondents showed interest in shifting to old age home. Those who said 'yes' to old age home were generally belonging to the poor families and were getting abused frequently by their near ones.

This shows that life is full of necessities. Some needs are general whereas others are specific and based on individuals' desires. But no life is possible without fulfillment of these basic needs. In old age when body shows decline e.g. in physical, mental and biological sphere; the life becomes difficult. In a situation like this, when deprivation to basic necessities was also added, the life becomes totally miserable. Hence, the variable 'availability of basic services' has been introduced to diagnose the basic problems of senior citizens. The findings clearly highlighted the deprivation of basic services in almost half of the cases.

As regards the occupation, it was found that 27.2 percent of the respondents belong to service class and were getting pension, 18.4 percent belong to labour class and another 10.6 percent belongs to business class. It was also observed that very few respondents (3.4 percent) in the young-old age group were doing some private jobs,11.2 percent had their agricultural lands and cattle, 6 percent were getting rent,6.8 percent were dependent on interest coming from their fixed deposits and only one percent were receiving old age and widow pensions. Besides, 15.4 percent of the respondents were dependent entirely on their family and friends.

The monthly income is also an important variable to determine one's quality of life. The findings shows that that the monthly income of 112 respondents (22.4 percent) was below Rs.1000 , followed by 82 respondents(16.4 percent) earning between Rs.1000 and Rs.5000 per month respectively i.e. considered as 'low' in the present study. There were 194 respondents (38.8 percent) belonging to lower income group. However, 106 respondents (21.2 percent) and 161 respondents (32.2 percent) were getting their income in the range of 5,000 to 10,000 and between Rs,10,000 to 20,000 respectively and were put in the category of 'moderate' income. However, the remaining 39 respondents (7.8 percent) belongs to the high income group as getting Rs. 20, 000 and above on monthly basis. Out of these, many (11 respondents) reported that their monthly income was even more than Rupees one lakh. Thus in total

61.2 percent of the respondents were getting sufficient income to fulfill their basic needs.

The monthly income is also related to the extent of saving. In old age saving becomes even more significant as it reflects the senior citizen's access to basic services including health, food, water and shelter. Those who had savings were able to utilize the best practices of health, food and housing etc. An overwhelming majority, 206 (41.2 percent) of respondents reported that whatever they earn is just equal to their expenditure and they had nothing in the name of saving. Further, they informed that whatever savings they had was all utilized in the upbringing, education and marriage of their children.

I.Rajan also brings forth similar results in his study based on Tamil Nadu, Kerala and Orissa. The above findings are also in line with the findings of Saraswati Mishra, who conducted her study on the retirees of Chandigarh and Jabalpur and found that both the Chandigarh and Jabalpur based respondents reported inadequacy of monthly income. The reason cited was the lower amount of Pension which is not sufficient to meet their basic requirements of life.

This shows that even the provision of pension does not bring quality to the life of senior citizens. This even put them into trouble at the time of emergencies and makes them dependent on their family and friends. This observation is fully supported by the findings of Moneer Alam who undertook his study in the nine districts of Delhi and found that two-third of the respondents were completely dependent on their respective families. The findings of R. Bakshi et.al, A. K. Panda and L. S. Talunkar and John A. Menachery also support this finding as majority of respondents in each study were found to be dependent on their family for their subsistence. Hence, in old age financial stability is must and which is generally found missing in present senior citizens. In a nutshell, it can be concluded that the younger generation must plan for having some savings for their old age and the elderly should keep some financial asset with them, if possible.

Keeping financial asset in old age is both a boon and a curse. It becomes a boon when it helps in maintaining the quality of life of senior citizens. It changes the attitude of family members towards them. Those who own some financial assets lead more satisfied life as they got all their requirements fulfilled. The financial assets turn out to

be a 'curse' when it leads to family conflicts and became a threat to social security. In the present study, the financial asset signifies the ownership of property, household, gold ornaments, vehicles, savings and animal resources etc.

The findings reveals that a very small percentage (27.2 percent) of the respondents kept two or three financial assets of good value with them, whereas, a large majority (38.6 percent) had either transferred it to someone else or left with the ownership of single household in which they were living. However, the remaining respondents 171(34.2 percent) did not hold any such asset and they were mostly females and males belonging to lower income groups. The present findings were fully supported by the findings of A. K. Panda as in her study only 11 percent were holding some property and 13 percent had jewellery, whereas, the remaining respondents were having no financial asset of their own.

Similarly, the findings of A.M. Khan partially support the present findings as study reported almost half (40.9percent) of the elderly holding some personal property whereas, 31 percent had property on the name of their spouse and 11.2 percent on their son's name. However, observation of P.N. Sati goes in contrast with the above findings as his study shows that majority (95.7 percent) of the respondents were holding some assets. L. S. Talunker and John A. Menachery also found that 74.3 percent of the respondents had not transferred their immovable property to anyone, even in their old age.

In addition to above findings, the study diagnoses a significant relationship in between ownership of financial assets and gender as chi-square value comes out to be 28.19 which is more than the actual value(5.99) at P=0.05 level of significance. The present findings suggests that majority of females (106) either do not owe any financial asset or have ancestral home as the only asset. However, a small number (65) of male respondents reported to have low financial assets. In general, a large majority of respondents (193) reported that they owe moderate level (one or two assets of good value) of financial assets on their names, whereas, 136 respondents reported to have financial assets of good value including few male (93) and more (43) females. Similarly, R. Chakroborty reported that 70 percent of the aged depends on others for their subsistence and females were highly vulnerable than males as only 31 percent of female respondents had an independent source of income. Similar findings

have been reported by Usha Bambawale in Pune. This shows that elderly females are more dependent on others for their basic necessities as compared to their male counterparts.

Along with gender, the finding suggests a significant relationship in between ownership of financial assets and level of education as chi-square value is more than the actual value at P=0.05 level of significance. Out of 500 respondents; 155 respondents either holding any financial asset or having ancestral home belongs to lower education group, whereas,10 respondents from moderately educated group and 6 respondents from highly educated group does not possess ownership of any financial asset. This shows that in old age mostly the ownership of financial assets decreases, but with higher education; the chances to retain more assets would have increased.

Economic hardship is a cause behind many socio-emotional problems. In old age, it adds up with physical dependence and liability to make the life of senior citizens more vulnerable. The Government, therefore has launched various schemes and policies meant to promote the well-being of senior citizens. But to gain the full benefits of these schemes requires the awareness, correct usage and accessibility of these schemes. To check this usage the variables 'awareness of welfare schemes' and 'the extent of utilization' of these schemes by the respondents have been introduced. For the sake of simplicity, focus would be given on those schemes which are commonly used by the respondents. First to analyze is the Old Age Pension Scheme (OAPS). It was found that out of 500 respondents; majority 394 respondents (78.8 percent) were knowing the benefits and correct usage of OAPS, whereas, a significant number of respondents 106 (21.2 percent) were even unaware of the procedure of making application.

While examining the reasons for not getting Old Age Pension (OAP); it was found that 291 (58.2 percent) respondents were not in a need of getting such help.130 (23.0 percent) respondents never tried for pension, whereas, 56 (11.2 percent) respondents found the procedure for application as difficult and the amount as meager. Out of those who had already applied for old age pension; 23(4.6 percent) would not receive it because of corruption. They reported that those who had to verify the application either demanded something in return or leave application unattended. They generally

signed the application of their close ones. This clearly shows the loopholes present in the implementation of social security measures.

Hence, the present need is to make the process of distribution flexible and transparent. Like the Right to Information Act; the procedure to submit application should be made easier as many of the senior citizens are still uneducated and dependent. Similarly, in case of Widow Pension (WP), a large number of respondents, 421 (84.2 percent) were found to be aware of the pension, whereas, a small number 79 (15.8 percent) shows their unawareness regarding the scheme. Further on looking into the access to other benefits, it was found that only educated respondents 182 (36.2 percent) were aware of financial benefits including tax reductions and high interest rates available for senior citizens on fixed deposits followed by 177 (35.4 percent) respondents who were aware of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007.

Similarly, I. Rajan also found the significance of education in the knowledge of various welfare schemes. His study reveals that most of the elderly were showing ignorance towards the welfare schemes just because of their lower education or illiteracy. Similarly, the findings of P. Mohananand Sajjan B.S. in Mangalore city of Karnataka based on senior citizens of old age home noticed that out of 1026 respondents, hardly 10 percent of the respondents were enjoying old age pension and 30 percent were enjoying retirement benefits. It was also found that male respondents were more aware about these advantages as compared to females, again showing the vulnerability of females. Similarly, P.N Sati in his study based on needs and problems of aged in Udaipur and Ajmer found that 53.4 percent knows about the welfare schemes. The present findings therefore suggest that majority of older people were not knowing the schemes meant for their welfare.

Since the study aimed at identifying the possible coping mechanisms, the question related to the perception of respondents regarding the best coping practices against financial hardship was examined. Basic aim was to check the respondent's use of rational thinking and attitude towards handling of the financial problems. The findings clearly indicates that more than half 325 (65 percent) of the respondents were in a favour of saving something in earlier stages of life. However, 73 respondents (14.6 percent) hold the view that one should try to get engaged in work till his/her health

permits as savings get utilized before the time of old age. However, forty-one respondents (8.2 percent) were in favour of keeping some immovable assets, fifty-five respondents (11percent) gave priority to socialization of children towards giving love and respect to their parents in the final stage of life, whereas, six respondents did not reply. The findings therefore suggest that majority of respondents support of having some savings for old age but the circumstances did not permit them to do so.

The study also highlighted the actual practices adopted by senior citizens in order to cope with financial crisis. The findings revealed that a large number of respondents 137 (27.4 percent) were depending entirely on their children for financial support. However, ninety six respondents (19.2 percent) used to cut down their expenses and try to manage within the available limits. Further if needed, they ask their children for help and if the crisis still exists, they left everything on god. Out of remaining, five percent reported that they sold out their assets if they had, whereas , others were in a habit of borrowing money from someone as 77 (15.4 percent) respondents borrowed money from their friends, 28 (5.6 percent) from their relatives and 43 (8.6 percent)from money lenders. Moreover, five respondents (1 percent) used to take loan on their pension and other assets whereas, only one respondent reported that he used to search for some better employment. However, only eighty eight respondents reported that they never faced any kind of financial crisis in their old age. This is because of their good earning and some earlier savings. Hence, from above findings it can be concluded that in old age the expectations to receive help, increases and majority did not think of making any serious effort for solving their financial problems. The present findings were fully supported by the findings of M. S. Randhwa.

While looking into the impact of education on coping practices it was found that those who are highly educated were mostly facing no crisis , 37 respondents (41.11 percent) and if so, they used to ask children, 29 respondents (32.22 percent) and sold assets ,8 respondents (8.88 percent).In contrast, the lower educated respondents ask children for help; 94 respondents (26.40percent), cut down expenses; 79 respondents (22.19 percent) and borrow money from friends, relatives and money lenders; 131 respondents (36.79 percent) respectively.

Socio-economic problems had no significance if the health aspect has not been considered. Although health is the concern of every stage of life, but the level of concern rises as one enters the last stage i.e. old age. This is due to the fact that in old age; physical strength deteriorates and mental stability diminishes, which in turn leads to many health problems.

Hence after socio-economic problems, attempt has been made to diagnose the health problems of senior citizens. In this regard, first the perception of their present health status has been determined. A large number of respondents (40.4 percent) reported their health status as 'poor'. Those who reported poor health status were either belonging to the oldest-old age group or to the labour class. Similarly, 27.2 percent of the respondents reported their health status as 'average' followed by 25.2 percent respondents, considering them as 'good' as they had no major ailments instead of B.P. and lower vision etc. However, 36 respondents (7.2 percent) considered them as bearing 'very good' health status. They were mostly belonging to the young-old age group.

This shows that the 'age' as a variable has a significant impact on the health of senior citizens and with increase in age; the health problems generally increases. Similar findings have been reported by L. S. Talunker and John A. Menachery in a micro-level study conducted in Rural Vidarbha where significantly large number (57.1 percent) of respondents opined that their health status was 'bad'. Similarly, T. C. Joshua and D. T. Fiasta in their study observed that out of 231 respondents; 140 were suffering from various kinds of diseases and only 99 respondents promised of keeping good health. However, 42 respondents said that their health status is neither good nor bad. Dr. Saraswati Mishra in her study related independence with the health perception and determines that fully independent elderly (68.42 percent) are having a good perception of their health, whereas very few respondents who are partially dependent (4.24 percent) holds the similar view.

Sleep is the basic requirement of healthy body and peaceful mind. In old age, the body gets tired very frequently and requires more time for rest. The findings shows that majority of respondents 317 (63.4 percent) were in a habit of sleeping for more than eight hours a day. They mostly belong to the young-old age group. In addition, there were only 19 (3.8 percent) respondents who used to take a sleep of around five

to eight hours. In total, 164 (32.8 percent) respondents had expressed this kind of behaviour. This shows that with age, the pattern of sleep also gets affected. Similar findings have been reported by R.K. Punia et.al. where majority of rural (75.64 percent) as well as urban aged (55.38 percent) did not sleep properly. This shows that with age, the pattern of sleep also gets affected.

In addition to proper sleep, eating habits do had an impact on the health of senior citizens. Healthy eating practices make one feel healthy and energetic throughout their life. For instance, the American Psychological Association, highlighted that the diet rich in folate can help mitigate the feelings of depression, Dementia and mental impairment in senior citizens. The present study revealed that almost two-third of the respondents 385 (77 percent) were in a habit of having meals thrice a day and filled with essential nutrients as their diet includes all the basic vegetables, milk, curd, egg or/and meat and seasonal fruits. However, eighty six respondents (17.2 percent) reported that they used to take some light snacks and fruits in the evening along with three times meals. In addition, they take some energy giving health drinks and dry fruits etc. The findings also suggest that a very small percentage used to take meal twice 24 (4.8 percent) and once 10 (5 percent) in a day. They were generally belonging to lower income group and were not having access to nutritional meals. Whatever they had as food is to fill their hunger.

Further, it was found that gender plays no significant role in the intake of food habits as the chi-square value comes out to be 4.054 which is lesser than the expected value of chi (5.991) at 0.05 level of significance. The findings reveal that only a small number of respondents (11) were in a habit of taking 'below average' diet i.e. meals once in a day. The habit was almost similar in both the genders as 8 females and 3 males reported the similar pattern, whereas, a large majority of respondents (297), irrespective of gender (152 females and 145 males) used to take meals thrice.

Activities of Daily Living (ADL) is another variable which determines the individual's status and role within the family. Health professionals even use the ability to perform ADL as a measurement of the functional status, particularly with regard to people with disabilities and the elderly. Activities of daily living (ADL) refers to the things elderly normally performed in doing daily living such as feeding, bathing, dressing, grooming, homemaking, and leisure etc. The findings clearly

reveals that a large number of respondents 434 (86.8 percent) were doing their ADL by their own. They all belongs to the young-old and the old-old age group, whereas, sixty-six respondents (13.2 percent) either falling in the oldest-old age group or were seriously ill used to take help of others in doing their ADL. This shows that lower the age of the respondents, higher will be the ability to perform their ADL by their own. This is generally due to decrease in health with age. Similarly, A. Bose and M. S. Kapoor in Delhi found that majority of respondents were able to do their ADLs by their own. In contrast, Moneer Alam in his study in Delhi reported that a large number of respondents were suffering from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs, etc.) as well as in sensory health domains (hearing and vision).This makes them dependent on formal or informal help in doing their ADL. This dependency is acute in lower income group as compared to higher income group. It was also highlighted that females were doing their ADL more as compared to their male counterparts.

The study also outlines the number of ailments found among the senior citizens and reported that out of 500 respondents; majority 353 respondents (70.6 percent) were suffering from major health problems, whereas, 92 (18.4 percent) respondents undergo some minor illnesses. However, 55 (11.0 percent) respondents were not facing any kind of serious health issue. Among the major health problems, more than half of the respondents (56.8 percent) were facing the problem of arthritis / joint pain followed by T.B (21 percent), Cancer (27 percent) and Asthma (23.8 percent). In addition, Osteoporosis was reported by 84 (16.8 percent) respondents followed by Kidney failure/ Paralysis 78 (15.6 percent), Diabetes; 68 respondents (13.6 percent), heart and lung related disorders; 45 (9 percent) respondents and severe memory loss by 6 respondents (1.2 percent) respectively. Among the minor health problems; the problem of high/low B.P. was reported by 356 (71.2 percent) respondents followed by lower vision or hearing 312 (62.4 percent) respondents and cataract by 225 (45 percent) respondents. Almost similar nature of health problems were reported by M.S. Randhwa, R.K. Puniaet .al., T.C. Joshua and Diengdoh, T. Fiasta and Menachery et.al.

Therefore, the above findings clearly reveal that with increase of age, the severity towards health problems increases. In addition, it was found that a significant relationship exists in between health problems and gender as chi-value comes out to be 13.435 which is greater than the actual value (5.991) at 0.05 level of significance.

The finding further indicates that majority of respondents (353) were facing one or the other major ailment.

On looking into the gender differences, it was found that females were suffering more from major diseases (193 respondents) as compared to minor (33 respondents) and no health problems (34 respondents). Similar pattern was observed in the male respondents with having 160 suffering from major health problems, 59 from minor and remaining 34 with having no health issues. The reason why the majority of females undergo severe health problems is their careless attitude towards self. Similarly, P. Mohanan et.al. in her study based on Mangalore city compared the gender differences in health and found that males had more number of chronic illnesses as compared to females e.g. Cataract (30.6 percent M, 19.7 percent F), Diabetes (40.2 percent M, 21.8 percent F), Hypertension (24.6 percent M, 12.8 percent F), Arthritis (5.4 percent M, 6.4 percent F), Asthma (1.9 percent M, 8.8 percent F).Thus it can be concluded that with advancement of age; the number of diseases increases and it was more in case of females.

Ignorance is generally the cause behind many health problems of senior citizens in India. In many cases, ignorance even leads to death. The present findings therefore indicates that a large majority of respondents 402 (80.4 percent) were in a habit of ignoring their health problems; whereas, only 98 (19.6 percent) respondents had shown their concern towards the treatment and care of their health as they never forget to take treatment in the case of any illness (either minor or major). Further, there is found no significant relationship in between the increasing age (young-old, old-old and oldest-old) and the ignorance of health problems as chi value comes to be 3.255 which is lower than the actual value of chi (5.991) at 0.05 level of significance. This shows that ignorance of health problem is a common characteristic in old age.

Along with self ignorance, the senior citizens experience the problem of ignorance by their family members and the problem of 'grand dumping'.'Grand dumping' signifies the ignorance of parent's or grandparent's health by their children and finally dumping them into old-age homes or somewhere else. The findings reveal that a significant percentage (27 percent) were facing the problem of ignorance of health by their children, whereas a large majority of respondents 365 (73 percent) had never been ignored by their family in terms of health and other related matters. The basic

reason behind the concern of family was the prevalence of joint family system and social obligations of giving love and respect to their parents.

In urban areas, care receiving at the time of poor health is also amongst the basic challenges of old age. Urban cities are more influenced by nuclear family system. In the present study the informal care giving has been considered where caregivers include son, daughter, spouse, relatives, friends or someone who help them in doing their activities of daily living. About half of the respondents 269 (53.8 percent) reported the primary caregiver as their spouse. However, many reported their son 91 respondents (18.2 percent) and daughter 41 (8.2 percent) respondents as their primary caregiver. In addition, the other caregivers were identified as daughter-in-law; 62 respondents (12.4 percent), neighbours and friends; 12 respondents (2.4 percent) and relatives; 9 (1.8 percent) respondents respectively.

The findings further revealed that the senior citizens who are living alone have been cared of by their servants; 5 (1.0 percent). There were very few respondents (2.2 percent) who reported no caregiver. The findings of P. Mohanan et.al. fully supported the present findings as it was found that spouse (148; 120M, 28F) was the primary caregiver followed by self care (140; 22M, 118F); son or daughter-in-law (130; 20M, 110F), grand-children (72; 12M, 60F) and others (57; 18M, 39F). Similar is the findings of Anne Gray in Great Britain which suggested that with increasing age, care giving was restricted to spouse or adult children than to non-kin and relatives. Those who are living alone are cared by their friends. Hence, the primary caregiver in old age is the spouse and other family members.

On looking into the impact of gender on care giving it was found that females play the role of care giving more as compared to the males (286 females over 214 males).The findings are totally in agreement with the findings of N. Bano and C. Mayuri where majority of caregivers were females (73percent) in age the group of 36-40 years and half of them were housewives. Similarly, the findings of C. J. Thomas and F. T. Diengdoh also supported the present findings. Further, the study highlighted no significant relationship in between the number of siblings and the amount of care giving provided by them as out of those who had been cared by their servants, relatives and friends do reported the presence of two or more siblings. Hence, the presence of children either less or more does not guarantee care in old age.

Intake of unhealthy substances; like alcohol, drugs, cigarette, bidi, tobacco etc. also affects the health of senior citizens. Although the intake of unhealthy substances is found less prevalent in the elderly age group, but its usage brings significant health hazards. The findings suggest that a large number of respondents; 302 (60.4 percent) were not in a habit of taking any unhealthy substances but a significant number of respondents; 198(39.6 percent) still consumed unhealthy substances. Out of them, 56 respondents (11.2 percent) were addicted to cigarette followed by bidi 41 (8.20 percent) respondents, pan with tobacco 28(5.6 percent) respondents, gutka 23 (4.6 percent) respondents and alcohol 15 (3 percent) respondents respectively. Remaining thirty five respondents (7 percent) used to take two or more substances together like bidi and alcohol, cigarette and alcohol, bidi and tobacco etc.

Similarly, L. S. Talunker and J. A. Menachery in Nagpur found the consumption of tobacco as the most frequent (68.5percent) unhealthy practice adopted by senior citizens followed by the consumption of alcohol (14.3percent); chillum (51.4percent) and bidi (14.3percent). Similarly, R.K. Punia et.al. compared unhealthy practices in rural and urban areas and noticed smoking (61.53percent in urban and 52.17 percent in rural areas) and drinking alcohol (urban; 4.61 percent and rural; 6.08 percent) as the two most common practices. However, the consumption of bhang 17.39 percent and opium (2 percent) was also prevalent in rural areas. This shows that elderly people do search for unfair means in order to get relief from their tensions and stressors.

The health problems would not affect senior citizens adversely if the proper treatment would be given to them. In India we had many healthcare systems consisting of Ayurveda, Yoga, Siddha, Unani, Homoeopath, Allopath, and Naturopath. Although each system has its own significance but the need is to check the access and availability of each with regard to the elderly care and usage. In this regard, it was found that majority (73 percent) of respondents were in a habit of utilizing Allopath as a means of healthcare followed by Homeopath;62 (12.4 percent) respondents, Ayurveda; 50 (10 percent) respondents and Unani; 23 (4.6 percent) respondents. However, none of the respondent follows Yoga, Naturopathy and Acupuncture. This shows that 'Allopath' is the most frequent choice of medicine among the senior citizens. This is due to its easy access and faster healing ability. Dr. Saraswati Mishra also identified Allopathy, Homeopathy and Ayurveda as the three major systems of medicines adopted by senior citizens at the time of any health crisis.

Out of these; 61.67 percent preferred allopath, 7.07 percent preferred ayurveda and remaining (2.33 percent) preferred homeopath. This shows that allopath is the most frequent choice of medicine among the senior citizens and needs more promotion and access.

Further an attempt was made to diagnose the source of treatment adopted by the senior citizens and reason for its adoption. The present findings revealed that more than half of the respondents 279 (55.8 percent) were taking the help of private doctors, whereas, government hospitals were approached by only 104 (20.8 percent) respondents. The findings also suggests that mostly upper and middle income group were utilizing the services of public hospitals, whereas, those who had lower income followed the treatment from Quacks; 42 respondents (8.4 percent), Chemist shop; 38 respondents (7.6 percent), Vaid / Hakim; 27 respondents (5.4 percent) and free health camps; 4 (0.8 percent) respondents respectively. Private and expensive services were bare by only 6 (1.2 percent) respondents. This shows that the government health services are still serving as a lifeline to many senior citizens.

In order to check the reason behind the utilization of specific system; the question as to what extent they were utilizing and why has been asked. In response to this, the majority of respondents 249 (49.6 percent) reported the reason for utilization of such system as the availability of good services and effective results. However, another 194 (38.8 percent) respondents reported the reason behind their utilization of such services was the availability at lower cost. The remaining respondents (10 percent) preferred the reported system of medicine just because of its easy access. A very small group of respondents (1.6 percent) had no other choice, except to follow the available system. This shows that older people are not utilizing health care services as per their need rather they make forced choices.

Presently, the government is providing health care services at three levels, namely, primary, secondary and tertiary level. The primary level includes Health Centre (HC) with basic facility; secondary level includes Community Health Centre (CHC) and District Hospitals. whereas, tertiary level includes medical colleges, Hospitals and research institutions. The findings reveal that more than half of the respondents 289 (57.8 percent) were not utilizing the government services because of overcrowding. This was followed by negligence of staff 77 (14.4 percent), transport problems 50

(10.0 percent) and financial shortages 45 (9.0 percent) respondents respectively. However, 44 (8.8 percent) respondents did not have any problem in utilizing the government hospitals because of having their own relatives and friends working as a staff in the hospitals.

Thus, overcrowding in government hospitals was found to be the basic cause behind the non-utilization of government services. Similar is the findings of Dr. Saraswati Mishra where government hospitals were preferred by 29.25 percent, nursing homes by 6.85 percent and private doctors by almost half of the respondents (50 percent). Higher proportion preferring private doctors are mostly due to negligence they found in the government hospitals. In addition, L. S. Talunker and J. A. Menachery in Nagpur observed that 77 percent of the respondents did not prefer PHC services in villages due to dissatisfaction from services. Similarly, M.S. Randhwa observed that 52.8 percent rural and 47.2 percent urban did not get proper care in the hospitals. In similar line, A. K. Panda assessed that 27 percent elderly faces inappropriateness in services of government hospitals.In addition, C. J. Thomas and F.T. Diengdoh in their project on 'Ageing in Meghalaya' also came up with similar results by stating that those who want to access government hospitals expressed dissatisfaction over services (40 percent) followed by complaints of waiting for a long time (16 percent), doctors do not attend them (10 percent), doctors do not provide proper medicine (9 percent) and does not receive attention from other staff members (8 percent). Hence, need is to provide more hospitals and dispensaries with having special geriatric wards.

It's true that with age body shows decline. But it's also true that the preventive measures like regular exercise, walking, yoga, nutritious diet, remaining busy, managing stress, regular health checkups etc. can help in reducing the ill effects of ageing. It further makes one feel energetic, fit and at reduced risk of disease. In terms of healthy life styles; majority of respondents; 207 (41.40 percent) were in a habit of following one or two healthy life styles, followed by 201(40.20 percent) respondents following between three to five life styles, whereas, 70 respondents (14 percent) followed between six to eight life-styles on a regular bases. However, a very small number of respondents 22(4.4 percent) denied to follow any such activity. It was also found that those who were not following any healthy life styles were either bed ridden or belongs to oldest-old age group (80+ yrs).

Further, the individual life styles followed by the respondents were studied and it was found that 226 (45.2 percent) respondents used to go for a morning walk, 45 (9.0 percent) respondents does yoga or exercise, 125 (25.0 percent) visit their near ones and 32 (6.4 percent) respondents went on tours respectively. However, a very few respondents were in a habit of having their regular health checkups 27 (5.4 percent), taking balanced diet 80 (16.0 percent) respondents and gaining knowledge on old age issues 49 (9.8 percent) respondents respectively. Moreover, a significant number of respondents (37.2 percent) spend their leisure time in participation of social and political events. Keeping pets, cycling and swimming etc. was also reported by 55 (11 percent) respondents. The above findings clearly highlighted that majority of respondents are not in a habit of following healthy life styles.

The study further assessed the impact of education on the healthy lifestyle followed by an individual as majority of the respondents (190) having lower education were in a habit of following only one or two healthy life styles followed by the highly educated group (10 respondents) and moderately educated group (7 respondents) respectively. However, 123 respondents from the lower educated group are in habit of following three to five healthy life styles followed by highly educated (41) and moderately educated (37) respondents. Similar is the case for more than six healthy practices. This shows that highly educated groups are practicing healthier life style more as compared to the respondents having lower and middle education.

In addition to healthy life styles, the use of helping aid can also make the life of senior citizens simpler. Helping aid for senior citizens generally includes digital monitor for diabetes, walker, spectacle, hearing aid, B.P monitor, oddly shaped reading material, portable magnifier, wheel chairs, notebooks etc. The present study indicates that out of the total of 500 respondents, only 176 (35.2 percent) respondents were not utilizing any helping aid, whereas majority of respondents 324 (64.8 percent) were using one or the other helping aid to make their life simpler. The most common aid used by the respondents comes out to be spectacles and walker.

It was further identified that age has a significant relationship with the use of helping aid. Amongst the users; 54.07 percent were from 60 to 70 age group,73.17 percent falls in 70 to 80 age group and remaining 87.87 percent respondents belongs to the age group of 80 years and above. This shows that in old age, people generally

depends on helping aid as their means of coping against their health problems and this dependency increases from young-old to old-old and to the oldest-old age group.

Health Insurance can also be used as an effective tool in meeting the expenses of health of senior citizens. In this regard, it was found that majority of senior citizens 381(76.2 percent) were not covered under any insurance. However, the remaining 119 (23.8 percent) respondents having health insurance are either from higher income group or belong to public sector undertakings. While checking the age-wise distribution of the use of health insurance; it was found that 75 respondents (26.78 percent) from 60 to 70 age group, 32 respondents from 70 to 80 age group and remaining 61 respondents in the age group of 80 years and above were covered under health insurance scheme. In total, 23.8 percent respondents were utilizing health insurance. This clearly shows that with increase in age of respondents; the utilization of health insurance as a means of coping against the health problems decreases.

On looking into their own choice of utilizing health insurance as a means of coping; it was found that 102 (20.4 percent) respondents denied for having such access. The reasons they gave for their denial includes their religious belief that insurance is against their religion, insurance cover is wastage of time and money and creates problem at the time of refund etc. However, a large majority of respondents 389 (77.8 percent) opined that health insurance is a good thing and every one must try to have it. However, the remaining respondents, 9 (1.8 percent) did not replied as they were totally unaware of the concept of health insurance.

In the final analysis; the respondents own perception of their old age has been considered. The findings indicate that out of 500 respondents, 210 were considering their old age as a normal experience, whereas , 206 (41.2 percent) respondents considered it as a 'curse'. However, a handful of respondents 55 (11.0 percent) evaluated their old age as a 'period of freedom from responsibilities' and only 29 (5.8 percent) respondents considered it as an 'achievement'. Those who considered it as a 'curse' were either belonging to lower income group or were physically dependent, whereas, those who considered it as a period of freedom from responsibilities were having sufficient income and proper caregivers. Similarly, that who earns very good income and share high social status considers their old age as an achievement.

In addition to above findings; the case studies were also conducted. The case studies reflected few interesting findings: First, senior citizens belonging to lower income group or were totally dependent considers their old age as a 'curse', whereas , those belonging to higher income group or were able to do their activities of daily living were still enjoying their old age. For them, old age is a period of freedom from responsibilities, whereas, others consider it as a period of struggle. Second; senior citizens, irrespective of their income, preferred living in their own home and with their close ones rather than living in any old age home. Third, health is the most common sector which affects almost every senior citizen and hence needs special concern and focused interventions. What is needed most is the attitudinal change towards the aged. Once the senior citizens started feeling their importance in the family and society, they started enjoying their life. For this, all the stakeholders including the media, the younger generation, the educational institutes, the NGOs, the policy makers, the politicians and the bureaucrats; all needs to join hands and work in a positive direction towards making the old age successful and healthy.

Hypotheses Testing and Results:

The present study purposes to test the following hypothesis:

- **Females are more vulnerable than males in terms of their social status, decision making power, nutritional intake, ownership of assets and health status.**

In order to test this hypothesis; the following sub- hypotheses have been assessed:

Females are more vulnerable than males in terms of their social status.

The chi-square test on gender and social status of elderly has materially significant relationship as the calculative value (23.44) is more than the actual value (5.99) at 0.05 level of significance. Hence, the present null hypothesis is accepted i.e. females are more vulnerable than males in terms of their social status.

Females are more vulnerable than males in terms of their decision making.

The chi-square test on gender and decisioo making was found to be significant at 0.05 percent level of significance as chi-value (12.403) comes out to be greater than the actual value (3.841).This shows that there is a significant relation in between the gender and decision making and further checking the gender differences it was found

that decision making in important matters was generally shared by the males. Hence, the present hypothesis is accepted.

Females are more vulnerable than males in terms of their nutritional intake.

The chi-square test on gender and nutritional intake of elderly has no materially significant relationship as the calculative value is lesser (4.054) than the actual value of chi (5.991) at 0.05 level of significance. The findings shows that there is no relation in between the gender and the dietary intake in old age as both the genders were showing the similar patterns of diet. Hence the present hypothesis is rejected.

Females are more vulnerable than males in terms of ownership of financial assets.

The chi-square test on gender and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-value comes out to be 18.19 which is more than the actual value (5.99). The findings highlighted the dominance of males over females in possession of financial assets. Hence, the present hypothesis is accepted.

Females are more vulnerable than males in terms of health problems.

The chi-square test on gender and health status was also carried out and the findings revealed a significant relationship in between the nature of health problems and gender as chi-value comes out to be 9.435 which is greater than the actual value (5.991) at 0.05 level of significance. Females were affected more by the major diseases as compared to the males. Hence, the present hypothesis is accepted.

Thus on the basis of the testing of above mentioned hypothesis it could be inferred that females are more vulnerable than males in terms of social status, decision making power , ownership of assets and health status. However, they were not differentiated on the grounds of dietary intake. But still the quality of diet reduces in old age. Hence the primary hypothesis was tested and found true and objective one and two are therefore achieved.

- **Socio-economic problems increase with age. It is highest in oldest-old age group than in old-old and young-old age group.**

In order to test this hypothesis; the following sub hypotheses have been assessed:

With increase in age of the respondents; social status decreases

The chi-square test on age of respondents and social status has materially significant relationship as the calculative value (17.325) is more than the actual value (7.82) at 0.05 level of significance. Hence the present hypothesis is accepted.

With increase in the age of the respondents; decision making power decreases

The chi-square test on age of the respondents and decision making was found to be significant at 0.05 percent level of significance as chi-value (16.715) comes out to be greater than the actual value (5.99).Hence the present hypothesis is accepted.

With increase in the age of the respondents; ownership of financial assets decreases

The chi-square test on gender and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-value comes out to be 12.329 which is more than the actual value (7.82). Hence, the present hypothesis is accepted.

With increase in the age of the respondents; severity of health problem increases

The chi-square test on gender and health status was also carried out and the findings revealed a significant relationship in between the nature of health problems and gender as chi-value comes out to be 23.27 which is very much greater than the actual value (7.82) at 0.05 level of significance. Hence, the present hypothesis is accepted.

Thus on the basis of the testing above mentioned hypothesis it could be inferred that with increase in age of an individual from 60 years to seventy or to the eighty and above age group; his/ her body started to show decline in almost all spheres making the individual vulnerable . Hence, the primary hypothesis was tested and found true. Thus objectives one and two are achieved.

- **Social security increases with education. Those with higher education may have more ownership of assets and awareness towards the government schemes.**

Higher education leads to more ownership of financial assets.

In old age the ownership of financial assets generally decreases, but with education it keeps on increasing. The chi-square test on education and ownership of financial assets was found to be significant at 0.05 percent level of significance as chi-square value comes out to be 18.02 which is more than the actual value i.e. 9.48. Hence the present hypothesis is accepted.

Higher education leads to more awareness of Government Schemes (especially Old Age Pension).

The chi-square test on education and awareness of Government Schemes was found to be significant at 0.05 percent level of significance as chi-square value comes out to be 12.389 which is more than the expected value (5.991) at 0.05 level of significance. Hence the present hypothesis is accepted.

- **Religion serves as an effective tool for coping against distress.**

The present findings suggest the dominance of two religious groups in the sample only e.g. Muslims and Hindus. An attempt has also been made to diagnose whether religion makes an impact on the nature of old age problems. Whether it serves as an effective tool for coping against difficult life-situations e.g. at the time of distress, psychological and emotional problems etc or not. It was also found that Out of 500 respondents, almost half of the respondents 229 (45.8 percent) were using religion as a means of coping against psychological and emotional problems, whereas, 144 (28.8 percent) respondents reported to follow it sometimes. Further females were more involved in religious practices as compared to their male counterparts. This shows that religion serves as an effective tool for coping against distress. Thus second objective was achieved.

- **Migration after the age of sixty may leads to more socio-economic problems.**

The present findings indicate that only 63 (12.6 percent) respondents had reported migration to Aligarh within last one decade. Out of those who migrated, 'adjustment' was found to be the most frequent problem associated with migration (44.46 percent) followed by the problem of loneliness (30.15 percent) and reduced social interaction (25.39 percent). Hence, from the above findings, it can be inferred that majority of senior citizens were settled in Aligarh from a long time and hence, they were not affected by the impact of migration. But those who experienced migration, used to

face some problems. Hence the present hypothesis is accepted and the second objective of research was achieved.

- **Elder abuse is the least reported phenomena in old age.**

Out of the total of 500 respondents, 70 percent refused to have any form of abuse , whereas, only 30 percent reported it. Almost two-third of the respondents did not reply on the question of getting abused at home or outside the family. Similarly, there were seventy respondents (14 percent) never reported to any one, not even to their spouse, 28 respondents (5.6 percent) felt free to discuss the incidences of abuse with their friends, 5.0 percent discussed it openly with their spouse, 3.0 percent with neighbours, 1.8 percent with family members and very few (0.6 percent) discussed it with their relatives. Hence, on the basis of above findings, the present hypothesis is accepted leading to the achievement of research objective as well.

- **Primary caregivers in old age are the spouse and the family members.**

In the present study, it was found that in most of the cases, a single individual carries the burden of care giving. The findings also indicates that about half of the respondents 266 (53.2 percent) were taken care by their spouse followed by siblings including son (18.2 percent) and daughter (8.2 percent) as their primary caregivers. Similarly, the other caregivers include daughter-in-law, 62 respondents (12.4 percent); neighbours and friends, 12 respondents (2.4 percent); relatives, 9 respondents (1.8 percent) and servants 5 respondents (1.0 percent) respectively. However, very few respondents 11 (2.2 percent) reported no caregiver at the time of their illness. Hence, on the basis of above findings, the present hypothesis is accepted.

- **Senior citizens are in a habit of ignoring their health problems.**

Ignorance of health problems is very common among the senior citizens. The findings indicates that a large majority of respondents 402 (80.4 percent) were in a habit of ignoring their health problems; whereas, a small number of respondents 98 (19.6 percent) have shown serious concern towards their health as they never ignored their ailments either minor or major. Hence, on the basis of above findings, the present hypothesis is accepted.

- **The ability to cope decreases with age and hence the old age needs more assistance and support.**

The present study indicates a significant relationship between the coping practices adopted by the respondents and the age of respondents as the chi value comes out to be 17.325 which is greater than the actual value at 0.05 level of significance. The findings revealed that majority of respondents 379 (75.8 percent) adopted for Emotion Focused Coping. The Problem Focused Coping was found to be the choice of only one-fourth of the respondents (24.2 percent).

The findings also revealed that the problem focused coping has been showing decreasing trend as 26.27percent respondents from the age group of 60 to 70 years, followed by 25 percent from 70 to 80 age group and 13.63 percent in above 80 years age group used to follow the problem focused coping. This pattern clearly shows that with advancement of age; the capacity to solve any problem decreases and hence they adopted the easier way to come out of it in terms of emotion focused coping.

Coping against health problems indicates that majority of respondents 381(76.2 percent) were not having any kind of health insurance. It was also found that 119 (23.8 percent) respondents who are having health insurance are either belonging to higher income group or to the public sector.

Further, on looking into the age- wise distribution of the use of health insurance it was found that the age of respondents has a significant relationship with the use of health insurance (chi value = 12.931 > 5.991 at 0.05 level of significance). The findings further reveal that 205 (73.21percent) respondents from 60 to70 age group, 115 (78.23 percent)from 70 to 80 age group and remaining 61(83.56 percent) respondents in the age group of 80 years and above are not utilizing the benefits of any kind of health insurance. Thus on the basis of these findings, the above hypothesis is accepted and hence the third objective is also achieved.

Implications of Socio-economic and Health Problems

There are wide ranging implications of socio-economic problems of senior citizens. Some of which are discussed as follows;

- Socio-economic problems may increase with age
- Problems of senior citizens are interconnected in nature.

- Females are more vulnerable than males in terms of socio-economic problems.
- Education directly affects an individual's source of earning.
- Significant number of people suffers from elder abuse.
- Females were more vulnerable than males in terms of abuse.
- There will be an ascendance in the abuse as the age of senior citizens increases.
- Elderly will suffer more from a variety of health problems.
- With increase in age; the health problems generally increases.
- Ignorance of health problem is a common characteristic of old age.
- With increase in age, the pattern of sleep gets affected.
- A healthy eating practice makes one feels healthy and energetic.
- An Activity of Daily Living determines the individual's status and role.
- Care giving in nuclear families will continue to be a problem.
- More nuclear families in cities will generate the problem of social security for elderly.
- Older people will make forced choices in the utilization of health care services.
- Primary care giver in old age is the spouse.
- Lesser proportion of married elderly will have care giving problem as compared to single and widows/widower.
- Migration in older years will bring the feeling of isolation and boredom.
- With advancement of age, the capacity to deal any problem decreases and hence the elderly will adopt emotion focused coping.
- With advancement of age, the interest towards following healthy life-styles may decrease.
- Economic hardship is a cause behind many socio-emotional problems.

- Financial hardship increases with the advancement of the age of elder generation.
- Females are more vulnerable than males in terms of ownership of financial assets.
- Financial independence in old age is a must.
- Elder women will witness erosion of authority and decline in the participation of decision making.
- Elderly widows need to be given special assistance along with pension.
- In absence of social security; elderly perceive themselves as burden.
- Old age brings a feeling of loneliness.
- Religion will play a significant role in coping with difficult life-situations.
- Need for Old Age Home is going to increase in the near future.
- The amount of Old Age Pension needs to be revised and made flexible.
- Geriatric health care services are positively required for bringing quality of life to the elderly.
- Loopholes present in the implementation of social security measures needs to be checked.
- Other than familial support, NGOs and other formal organizations will have to take responsibility of providing formal care giving to the elder generation.

Policy recommendations and suggestions

The old age problems are multi-dimensional ranging from social, psychological, emotional, economic and health aspects to that of neglect, social security and isolation. In India, the senior citizens belong to various localities (e.g. rural, urban and tribal) and had different socio-economic needs. This is because of the individual differences experienced by them in their living conditions, cultural practices, religious

institutions and social and personal beliefs. What is applicable in urban areas is having no significance in rural areas. What seems to be the policy issue for one (oldest-old) age group may not be relevant for the other age group (young and middle-old elderly).

Considerable differences were also observed in case of their emotional, biological, financial and health needs. Hence, the elderly constitutes a homogenous group comprising of individual differences. These differences clearly pointed towards the need of taking the individual differences into consideration while planning any development programme for the welfare of aged. For this, differential planning is needed both at formulation and implementation level. Emphasis should be given on need based interventions rather than on making any attractive policy document.

Geographical Information System (G.I.S) should be implemented for aged data base, which will help in information management, monitoring and updating of information.

Courses on ageing and related issues should be included in the University, college and school curriculum level. Hence, for the overall well being of senior citizens, a multi-pronged approach is needed. This requires the joint efforts of government as well as of private organizations.

Moreover, the need is to make our elder generation organized because majority of senior citizens resides in rural areas with having no access to basic services and had negligible share in decision-making. Thus, first emphasis should be on making the 'grey power' visible and effective so that they can easily build pressure on the policy makers for developing effective programmes. For this, the government must initiate the formation of some associations for senior citizens both at the State and National level. These associations should also be given some financial assistance to make their work effective.

Further, on making an in-depth analysis into the problems of senior citizens, it was found that majority of senior citizens reported health problems, financial hardship, neglect and social isolation as their common problems. Out of these problems; 'health' needs special concern as majority of old age problems begins with poor health only.

No doubt, India's healthcare system is amongst the world's best health care systems. But in case of elderly population, it too needs modifications. This is because in urban areas; the overcrowded hospitals, long queues, far reaching hospitals and high cost of medicines and in rural areas; unavailability of services has all made it difficult for senior citizens to avail basic health care services. Many times the senior citizens did not approach to clinics and hospitals just because of their dependence on others. Thus, mobile elder care units should be provided in every district. Moreover, this service will be made available on elderly help lines. In addition, special geriatric wards may be introduced in every hospital so that elderly can get special care and attention.

For rural elderly, regular and well equipped health camps must be organized. Furthermore, an effective health insurance system with having transparency and easy affordability is required. There must be a provision on behalf of every State to fund for those elderly who are frail and had no caregiver. If possible, the government must provide free and compulsory health services to all its senior citizens.

Every hospital must be provided with all modern facilities and a medical team comprising of geriatricians, social workers, psychologists, gerontologists and geriatric nurses etc. The urgent need is to focus on 'age- specific' and 'area- specific' health needs. In this line, a specific policy on health of senior citizens should be promoted.

NGOs, especially the fureign donors must be encouraged to invest for the well being of senior citizens. Moreover, healthy life styles like early detection of disease, regular health checkups, doing meditation or yoga/exercise and taking nutritive diet etc. must be promoted.

In addition to health, 'income' was reported as another variable which affects the quality of life of senior citizens in a similar way as it affects the other age groups. Financial problem was also among the major causes against the vulnerability of aged. Although in India, family provides maximum care giving and caters all the needs of elderly, but in case of those elderly who are either single or are neglected by their family members, special concern is needed. The replacement of age-based status by the function-based status further aggravated the problem. In old age, elderly shifted their functional responsibility to someone else. Those who had savings and some source of income felt good, but those who had no earnings wouldn't found any space

in decision making. This further lead to the feeling of reduced social status and loss of self esteem. Hence, financial security in old age is a must.

But few important questions arises that who will provide financial security to aged? Whether India's financial status permits for providing income security to every household containing elderly? If not, does our government can offer some incentives to the families caring senior citizens e.g. tax reduction in salary, reduction in electricity and water bills, priority in house allocation to caregivers, special leave with pay for fix days etc.

As we know that there are two groups of senior citizens; one who are physically active and another who are dependent on others for doing their activities of daily living e.g. disable destitute and frail elderly. Those who are capable of doing some work should be engaged in some light jobs. Those who are unskilled should be given some vocational training for income generation. The introduction of micro credit and easy loan availability can also be helpful in improving the quality of life (QOL) of such elderly.

For dependent elderly, the need is to introduce adoption programmes like 'Adopt a grandparent scheme, 'Adopt a dependent aged' etc. Along with this, the Old Age Pension Scheme should need to be revised and raised periodically in accordance with the cost of living index. Further, the delivery mechanism requires simplification and easy accessibility as many elderly didn't register themselves because of the complexity of procedure. Further, those who are getting old age pension complained of not getting the amount on a monthly basis. Comprehensive social security system is the desired solution to this problem.

In addition, the elderly generation needs to learn that retirement from job does not signify the end of an active life. They had many more years to stay and remain active. The only thing needed is their positive thinking in the direction of beginning new interests and avenues. They may even think of work participation as it would bring not only the financial stability, but also reduces their stress of social isolation and loneliness.

In addition, the older people could be engaged in the management of crèches, orphanages, play schools, day care centre or in doing some light natured job. They can also be trained for participation in various counselling services, maintenance of public relations, managerial work, accounting and management of inventories etc. Hence, the need is to map all the resources (tapped or untapped) and develop the strategy accordingly. For this, the NGOs are required to come forward and make conscious efforts at national and international level.

Furthermore, the availability of limited funds at national and state level demanded us to promote the traditional family support system. Living in family not only saves national income but it also provides proper care, protection and emotional support to senior citizens. But this is not an easy task. It requires planning from the very initial stage i.e. at school and home level.

Emphasis should be on the reduction of intergenerational gap. For this, the youth need to teach healthy and encouraging attitudes towards aged. Simple gestures of sharing a cup of tea, passing a smile, offering love and respect are enough to change the life of senior citizens. In addition, the elderly need to be educated regarding their changing roles rather than sticking on the traditional role of care receiver. This requires the opening up of counselling and welfare centers in every district.

In this regard; the role of media is equally important because today's world is media driven and media has all the power to change the mindset of individuals. Today media has emerged as a weapon of mass mobilization. Media, either printed or electronic, can be used as a medium for spreading positive messages like ageing is a natural phenomenon, we must give love, care and support to our elderly generation, aged people are equally valuable as other age groups etc.

Hence, media can be used as an effective tool for strengthening intergenerational bonds. Media can also be used in sensitizing senior citizens towards their own rights and welfare measures. In addition, media can be used to generate awareness regarding the benefits of practicing healthy life styles e.g. exercise, nutritive diet, maintenance of personal hygiene, preventive health checkups etc.

In addition to above problems; the problem of social adjustment was also reflected in case of elderly living in cities. This is because of the housing shortage. The problem became more pressing in those families which are living in small houses as many senior citizens have been thrown out of their houses just because of small living space. Some have been shifted to old age homes whereas others had given no privacy. Hence, those elderly who are facing humiliation within their families must be offered chance to live in old age homes, whereas, those who are self sufficient and are capable of buying their own flats should be offered old age apartments equipped with all modern facilities.

Conclusions

From the findings some pertinent conclusions emerge which are as follows;

Senior citizens in India are having multifarious needs. But these needs require serious thinking on the part of the government and the civil society. Unless we find proper solutions to mitigate such problems; the elder generation will face more and more hardships both socially and economically. Thus, to address their problems an interdisciplinary and holistic approach is needed. The efforts should always be directed in improving the overall quality of life. In this regard, the government must commit some qualitative and need based research along with the provision of free services.

The Government should ensure free legal aid to all its senior citizens so that they can feel secure and enjoy healthy ageing. Since no government can provide all the facilities to every senior citizen, hence, individual efforts either of senior citizens or of younger generation should be promoted.

Aged women living in both economically urban areas and staying in nuclear families are facing enormous socio-economic and health problems. Ageing for women bring with it dependence, insecurity, poor health and declining care during illness. In an inadequate social security system in India, where abuse of the elderly women, financial hardship , economic independence are quite rampant, aged women constitute a vulnerable group which is often subjected to insult, injury, exploitation , inequality and injustice. Majority of elderly women are less educated, their public participation

is strictly limited. Therefore, it is of urgent need to make an intervention plan for the aged women which incorporates all the disadvantageous conditions of women and promotes the social upliftment along with generating some financial security.

The senior citizens must also change their mind sets regarding the new values imbibed by the younger generation. They should learn adjustment with new roles and focus on the limitations of old age, whereas, the younger generation could learn the lesson of love, respect and care towards the elder generation. They should recognize their elders as heir of experience and a valuable resource rather than being a burden of responsibilities.

In this regard, the role of NGOs can never be ignored. There are many NGOs e.g. Help Age International, Age Care foundation etc. which are working very efficiently for the welfare of elderly. They are helping senior citizens through a plethora of activities like training programmes, counselling services, family and group therapy, mobilization of resources; fund raising, running of welfare centre and day care centre etc. Hence, the public-private partnership is needed to improve the situations of elderly in India.

Further, it can be concluded that joined efforts of all the stakeholders including politicians, policy makers, youth, aged and other government departments is required for making the life of senior citizens healthy. All these stakeholders must look for the possible ways through which the position of aged will be improved.

For this, efforts like coordination of resources, avoidance of duplicity of services, development of database containing the socio demographic and economic profile of senior citizens is needed. Moreover, the government must promote qualitative, need based and policy oriented research following which the policy makers would develop some effective programmes. This requires the extensive participation of young minds in identifying the ageing issues. Need is to open some apex institutes like National Centre for Ageing Research etc. For this, the government as well as donor agencies must release funds.

In a nutshell, it can be concluded that unless old age problems are understood in totality, clearer picture of those problems is unlikely to emerge. Better comprehension of socio-economic, health and psychological problems along with appropriate and timely measures will go a long way in ensuring active and healthy ageing for senior citizens. One must not forget that older people are the reservoir of our wisdom and traditional values. So must be given full care and respect. It is the responsibility of everyone to make senior citizens realize that becoming "old" is an achievement of life and a blessing of god rather than a curse or a burden.

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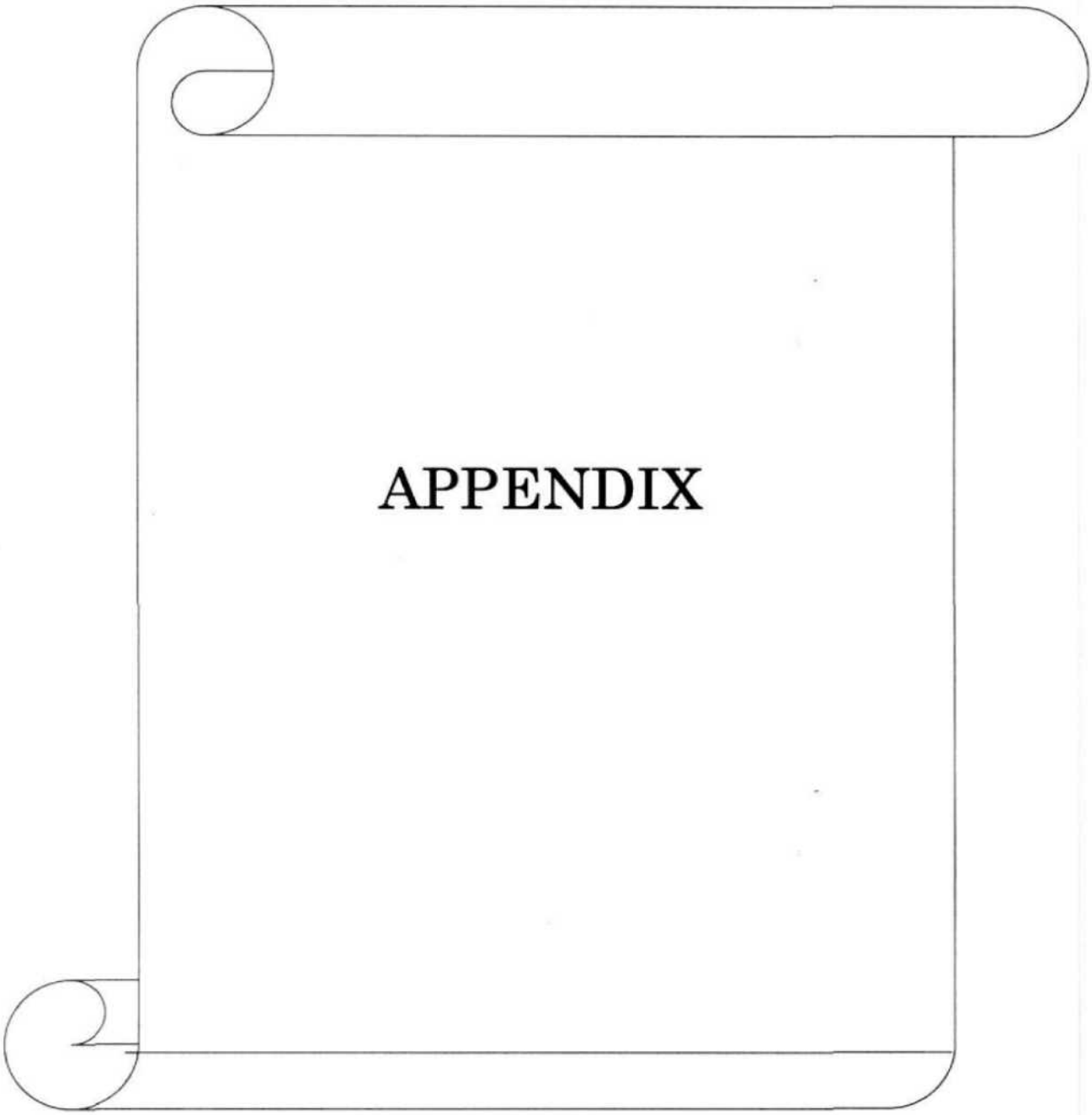
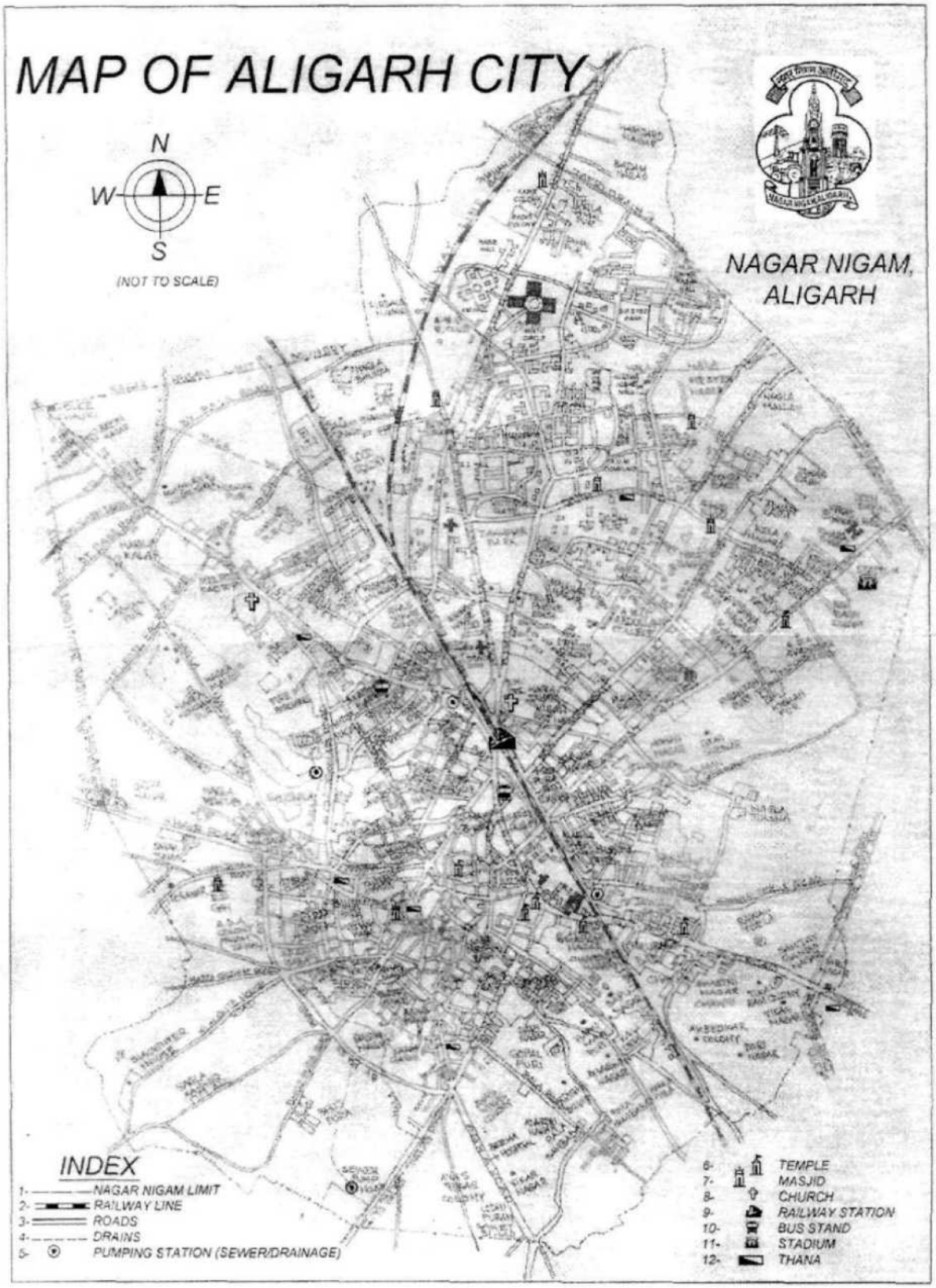


APPENDIX

Appendix

'Annexure -1'



'Annexure -2'

Interview Schedule

(For the purpose of the award of Ph. d. Degree in Social Work)

Age: _____yrs **Address (including ward):** _____

Sex: M ( )/ F ( )

Religion:

1. Muslim 2. Hindu 3. Sikh 4. Others ____

Socio-Demographic Profile:-

Q3. Are you a Literate? (Read and Write both)

1. Literate
2. Illiterate.

Q 4.What is your Highest Qualification?

1. Primary
2. Madarsa education
3. High School
4. Intermediate
5. Graduate
6. Post Graduate.
7. G Ph.D or Higher degree
8. Professional courses of PG level.

Q 5.What is your current Marital Status?

1. Married and Living with Spouse.
2. Married but not living with Spouse.
3. Widow or Widower.
4. Divorcee.
5. Single.

Q6.Type of your family?

1. Joint.
2. Nuclear.

Q7. In which type of dwelling are you living?

1. pucca House
2. Semi Pucca
3. Kachcha
4. Tin-shed
5. Jhuggi
6. Any Other_____

Q8. Total Family members (family size) of your Household? (Only with whom you are living)

1. (1 to 2)
2. (3 to 6)
3. (7 to 9)
4. (10+)
5. Alone.

Q9. Where do you sleep?

1. Separate Room
2. Common Room
3. Lobby/ Verandah
4. Kitchen
5. Other _____

Q 10. How many years do you have in Aligarh?

1. 0-5 yrs
2. 5-10 yrs
3. 10-15 yrs
4. 15-20 yrs
5. 20+ yrs
6. By Birth

Q 11. Why do you come here?

1. Children shifted here
2. Retirement
3. For treatment and Services
4. Natural Calamity
5. Any Other(Job, marriage, Education_____)

Q 12. Problems associated with migration?

1. Loneliness
2. Reduced Social Interaction
3. Difficulty in adjustment
4. Compact living space
5. Any Other_____
6. No. Problem

Q13. How many children do you have? (M and F both)

1. Living with you.
2. Living near you in the same city.
3. Living in another city.
4. Living Abroad.

Q 14. Nature of Help provided by the siblings in various matters

(mention a, b and c) {(a) frequently ; (b) sometimes; (c) never}

Matter of help given	Status of living of siblings			
	with them (a/b/c)	near in same city (a/b/c)	different city (a/b/c)	Abroad (a/b/c)
Financial				
Health				
Religious				
ADL				
Others_____				

Q 15. How often do you have conflicts with your family members?

1. Frequently 2. Sometimes 3. Never

Q 16. What was the main reason behind the conflict?

_____

_____

Q 17. Do you felt abused in the family? [YES ( ) / NO ( )]

A) If yes, what is the extent and nature of abuse?

1. Physical { frequently/ sometimes/ never}
2. Verbal { frequently/ sometimes/ never}
3. Financial { frequently/ sometimes/ never}
4. Psychological and Emotional { frequently/ sometimes/ never}
5. Sexual { frequently/ sometimes/ never}

Q 18. Who is the Frequent Abuser?

1. Spouse 2. Son 3. Daughter
4. Son-in-law 5. Daughter-in-law 6. Grandchildren
7. Relatives 8. Outsiders 9. Any other_____

Q 19. Whom do you report the incidence of abuse?

1. NGO 2. Police 3. Friends
4. Neighbours 5. Relatives 6. Family
7. Spouse 8. No One

If No One, Why?_____

Q 20 (a) Is Old Age Home a right place for the elderly people in need?

1. YES 2. NO 3. NO OPINION

(b) Do you prefer Old Age Home over your present living?

1. NO 2. YES 3. NO OPINION

If Yes, Are you able to pay for it?

1. Yes 2. Partially Pay the charges 3. No

Q 21. How you spent your Leisure Time? (Please Rank as 1,2,3,_____)

1. In Social/Political Participation
2. Performing Religious Duties
3. Visiting Somewhere
4. Doing Household Jobs
5. Reading books etc.
6. Playing (Cards etc.)
7. Grand parenting
8. Watching T.V. / Listening Radio
9. Gossiping
10. Any other_____

Q 22. Are you satisfied with your LTA?

1. Satisfied 2. Not satisfied 3. No Opinion

Q 23. How often do you feel lonely and loss of interest in life?

1. Always 2. Sometimes 3. Rarely 4. Never

Q 24. Please specify whether your family has sought your opinion or not in the following :

(1. Always 2. Never 3. self capable to take decisions)

1. Financial Matter	(A / B / C)
2. Education of Children	(A / B / C)
3. Marriage of Children	(A / B / C)
4. Religious Practices	(A / B / C)
5. Any Others_____	(A / B / C)

Q 25. What do you think about your current role and status in the family? Does it

1. Decline
2. Remain the same
3. Enhances
4. Not Sure

Q 26. Do you think media (T.V / Papers) is playing any role in changing the perception of younger generation towards the Aged?

1. Plays a positive role
2. No Role
3. Negative vc Role
4. No opinion
5. Depend on individual
6. Not applicable

Q 27. How often you use religion as a means of coping against Old Age Problems?

1. Always 2. Sometimes 3. Rarely 4. Never

Q 28. What would you do to overcome the problem of disrespect and loss of Self esteem?

1. Left everything on God
2. Involved more in religious cults
3. Went in Isolation
4. Get engaged in Household work
5. Discuss with friends and relatives
6. Try to solve
7. Seek professional Help
8. Any other _____

ECONOMIC PROFILE:

Q 29. Please specify which facilities do you have along with their nature?

(A) Independent (B) Common with Family (C) Public

1. Toilet 2. Bathing 3.Drinking Water
4. Telephone 5. Transport 6. Recreation

Q 30. Do you own any of these Assets? (specify Amount or value)

1. No Assets 2. Vehicles/ Jwellery 3. House/Flat
4. Land 5. Policies/ Bonds 6. Others _____

Q 31. What is your main source of Income?

1. Retiree-pension 2. Old Age Pension 3. Interest from Savings
4. Rent 5. Daily Wages 6. Salary from Job
7. Institutional Help 8. Others_____ 9. No Source **[GOTO Q 35.]**

Q 32. Range of your Monthly Income (from all your sources)?

1. 0-1000 2. 1001-3,000 3. 3001-5,000
4. 5,001-10,000 5. 10,001-20,000 6. More than 20,000.

Q 33. What major responsibilities do you share?

1. Fooding of Self and Spouse 2. Treatment of Illness
3. Upbringing of children 4. Education of Children
5. Marriage of Children 6. Others_____
7. No Responsibility

Q 34. Whether your Income is less, same or more than your monthly expenditure?

1. Less 2. Same 3. More

Q 35. Who provides financial support to you?

1. Spouse 2. Son/ Daughter-in-law 3. Daughter/ Son-in-law
4. Grandchildren 5. Relatives 6. Friends
7. Neighbours 8. Others 9. No One

Q 36 Frequency of providing support by them?

1. Daily 2. Weekly 3. Bi-Monthly
4. Monthly 5. Yearly 6. Once in a while

Q 37. Are you aware of Old Age Pension Scheme/Other Government Schemes?

1. Unaware 2. Partially Aware 3. Completely Aware

a. From which source do you know? _____

Q 38. Out of following which Scheme is Known to you?

1. Old Age Pension 2. Widow Pension
3. Tax Reduction on Loans etc. 4. Travelling Discount
5. Old Age Homes 6. Others_____

Q 39. Do you know about Parent's Maintenance Act of 2007?

1. Unaware 2. Partially Aware 3. Completely Aware

(a). If aware; Source of awareness_____ _____

(b). Are you availing the benefits of this Act? A. Yes B. NO C. No Need

Q 40. Please give reasons for not utilizing the benefits of following welfare schemes?

1. Procedure is difficult 2. Illiteracy 3. Dependence on others
4. Never try 5. Ineligible 6. Others (No need, Corruption,

A. Old Age Pension _____
B. Widow Pension _____
C. Tax Reduction on Loans etc. _____
D. Travelling Discount _____
E. Old Age Homes _____
F. Others _____

Q41. What according to you is the best way of dealing with financial crisis in old age?

1. Saving while earning
2. Doing job till health permits
3. Investment in Insurance
4. Borrow money from friends
5. Borrow money
6. Asked children for Help
7. Cut down expenses
8. Take Loan on property or pension.
9. Search for job or work
10. Any other _____

HEALTH PROFILE:

Q 42. How do you evaluate your present health status as?

1. Poor 2. Average 3. Good 4. Very Good
5. No Response

Q 43. How many hours do you sleep?

1. Difficulty in sleeping 2. 0-4 hours 3. 5-7 hours
4. 8-10 hours 5. More_____

Q 44. How many meals do you have in a day? _____

(a). What are these?

1. Breakfast 2. Lunch 3. Dinner 4. Evening snacks/ fruits

Q 45. What does your meal consists of?

_____

Q 46. How often do you take the following things?

(A. Frequently B. Often C. Never)

1. Bidi(A/B/C) 2. Tobacco(A/B/C)

3. Pan Masala (A/B/C) 4. Gutka(A/B/C)
5. Alcohol(A/B/C) 6. Drugs(A/B/C)
7. Pan(A/B/C)

Q 47. Which health problem do you have in last two years?

1. Alzheimer's Disease 2. Osteoporosis 3. Kidney Failure/ Paralysis
4. T.B./ Cancer 5. Heart and Lung Problems
6. Arthritis 7. Diabetes
8. Cataract 9. Low vision and Hearing
10. High and Low B.P. 11. Any Other (asthma, skin problems etc.___)

Q 48. Are you able to do ADLs on your own?

1. Totally depend on others
2. Depend for few activities
3. Yes

Q49.Who cares you the most during illness and in doing ADL?

1. Spouse	4. Son-in-law	8. Relatives	11. Neighbour
2. Son	5. Daughter-in- law	9. Friends	12. Servant
3. Daughter	6. Grandchild	10. Neighbours	13. No one

Q50. Reason why your family ignores your health problems?

1. Give priority to self and children's need
2. Busy schedule
3. Consider poor health as a normal sign of old age
4. Living very far and are unable to come
5. Do not ignore.

Q51. Give the frequency and reason of self ignore of health, if any?

(A. Frequently B. Often C. Never)

1. Financial crisis 2. Transport problem
3. Considering as a normal sign of Old Age
4. Feeling guilt in distributing others 5. Carelessness

Q 52. What system of medicine do you prefer most during illness?

1. Siddha/ Yoga 2. Ayurveda 3. Unani
4. Homeopath 5. Allopath 6. Home remedies

Q 53. From which source are you getting treatment most of the time?

1. private Hospitals 2. Private Practitioners 3.Government Hospitals
4. Local Hakim/ Vaid 5. Quacks 6. Home Remedies

(a). What was the main reason for utilizing these services?

1. No other alternative 2. Cheaper 3. shorter distance
4. Provide good services 5. Any other_____

Q 54. What problem do you face in the utilization of government health services?

1. Financial problem 2. Transport problem 3. Overcrowding
4. Discrimination 5. Others 6. No problem]

Q 55. Are you using any Helping Aid?

1. Yes 2. No; but needs 3. No and do not need

Q 56. Which one are you using?

1. Hearing Aid 2. Walking Stick 3. Spectacles
4. Dentures 5. Wheel Chair 6. Foot Wear
7. Any other_____

Q 57. Is health insurance needed in old age?

1. Must
2. Good to have and Important
3. Not needed
4. Don't Know about Insurance

Q 58. Do you have any health Insurance?

1. Yes 2. No 3. Don't knows about it.

Q 59. Out of these practices; which ones do you follow regularly?

1. Going for a Walk 2. Doing Yoga / exercise 3. Visiting near ones
4. Organising tours 5. Regular check-ups of health
6. Balanced diet 7. Participation in social/ political activities
8.. Gaining knowledge by reading on Old Age.

Q 60. How could you see your Old Age as?

1. Curse
2. Normal Experience
3. Period of freedom from responsibilities
4. Achievement
5. No opinion

Q 61. Can you prioritize your problems which you have shared with me?

1. Health 2. Financial 3. Psychological abuse
4. Adjustment 5. Food 6. Housing
7. Others (Loneliness, isolation, depression etc----------)